MAKING THE INDIAN HEALTH SYSTEM WORK FOR THE URBAN POOR

STRATEGIES FOR EXTENDING FINANCIAL RISK PROTECTION AND A CONTINUUM OF HEALTHCARE

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Mission

The Health Systems 20/20 **cooperative agreement**, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

Date

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ACRONYMS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APL	Above the Poverty Line
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AWC	Anganwadi Centre
BCC	Behaviour Change Communication
BPL	Below the Poverty Line
CBO	Community Based Organization
CDS	Community Development Society
CGHS	Central Government Health Scheme
CNA	Communications Needs Assessment
CMO	Chief Medical Officer
DGD	Delhi Government Dispensary
DHS	Directorate of Health Services
DMU	District Management Unit
DOL	Department of Labour
DRC	District Resource Center
ECHS	Ex-servicemen Contributory Health Scheme
ESIS	Employee State Insurance Scheme
FGD	Focus Group Discussion
FKO	Field Key Officer
GRC	Gender Resource Centre
GNCTD	Government of National Capital Territory of Delhi
HbCS	Haemoglobin Colour Scale
HLEG	High Level Expert Group
HLFPPT	Hindustan Latex Family Planning Promotion Trust
ICDS	Integrated Child Development Services
IEC	Information, Education, Communication
ILO	International Labour Organization
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor

MAMTA	Health Insurance Scheme
MC	Mission Convergence
MCD	Municipal Corporation of Delhi
MCH	Maternal and Child Health
MHO	Municipal Health Office
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MoHFW	Ministry of Health and Family Welfare
MoLE	Ministry of Labour and Employment
MVS	Mahila Vikas Sansthan
NABH	National Board for Accreditation of Hospitals and Healthcare Providers
NGO	Non Governmental Organization
NMEP	National Malaria Eradication Program
NRHM	National Rural Health Mission
OBC	Other Backward Caste
OOP	Out-of-Pocket Expenditure
OPD	Out-Patient Department
PHC	Primary Health Centre
PMU	Program Management Unit
PPP	Public-Private Partnership
RNTCP	Revised National Tuberculosis Control Program
RSBY	Rashtriya Swasthya Bima Yojana
RWA	Resident Welfare Associations
SC/ST	Scheduled Caste/Scheduled Tribe
SHG	Self-Help Group
SSK	Stree Suvidha Kendras
TB	Tuberculosis
TPA	Third Party Administrator
UHC	Universal Health Coverage
UHIS	Universal Health Insurance Scheme
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

REPORT PURPOSE

This report is an in-depth exploration of Health Systems 20/20 project activities in New Delhi, India carried out between 2009 and 2012. Health Systems 20/20, a global project funded by the United States Agency for International Development (USAID), provided technical assistance to the Government of National Capital Territory of Delhi (GNCTD) Mission Convergence program, locally called *Samajik Suvidha Sangam*. The GNCTD sponsors a number of social welfare schemes that strive to improve the health and well-being of the poor. Among them, health insurance promoted by the GNCTD aspires to extend financial risk protection against hospital expenses with the ultimate goal of reducing infant mortality, maternal mortality and out-of-pocket (OOP) expenditure on health. Mission Convergence is an innovative public-private partnership with local community organizations, called *Stree Suvidha Kendras (SSK)*, also known as Gender Resource Centres (GRCs). GRCs facilitate the delivery of welfare services to Delhi's poorest and are the implementation arm of Mission Convergence in communities.

PROJECT DESIGN CONTEXT

Health Systems 20/20 India activities sought to achieve the overarching goal of **increasing utilization of government-sponsored health insurance by the poor to reduce OOP expenditures for healthcare and improve health outcomes**. The project paid special attention to the problem of the covering the "last mile" — ensuring the health system includes strong mechanisms to extend access to insurance and health services at the community level. With the pace of urban growth in Delhi outstripping the existing infrastructure for healthcare, water, sanitation, and other services, many slum dwellers lack access to basic services. The poor's overall vulnerability to health issues can be mitigated with strengthened public systems for accessing government-sponsored insurance along with preventive and primary healthcare. Robust systems help the poor avoid high OOP expenses. Better systems also provide more opportunities for them to receive treatment early before illnesses progress and require more expensive levels of care. They also deter reliance on more expensive private providers or medically risky unlicensed practitioners.

Two major research activities provided important contextual information to inform the design of Health Systems 20/20 strategies. First, an informal process mapping exercise reviewed the implementation system for *Rashtriya Swasthya Bima Yojana* (RSBY; translated: National Health Insurance Scheme). While examining systems for RSBY implementation, Health Systems 20/20 found that operational and implementation flaws compromise the ability of the Delhi government to reach its intended beneficiaries for government-sponsored health insurance. Second, a 2010 baseline survey of slum households was carried out by the project. The survey substantiated the process mapping findings. It indicated that respondents had limited knowledge of government-sponsored insurance options available to them and low use of preventive healthcare. The survey in particular shed light on the numerous demand-side and supply-side factors that affect the extent to which the urban poor access and use available financial risk protections and health services. These factors were examined prior to designing and implementing Health Systems 20/20 strategies. They were further considered when contemplating the technical and program management skills required by Mission Convergence Program Managers and GRC functionaries to carry out their health mission.

TECHNICAL ASSISTANCE OVERVIEW

The 11-month field collaboration between the Health Systems 20/20 project and Mission Convergence piloted strategies for making a significant difference in how the poor access and utilize the health system. The project's inclusive approach sought to shed light on the different facets of the health system — from health insurance mechanisms to public and private service delivery providers to community organizations to public health managers — all which are linked and must work in concert to affect the behaviours of the poor. Health Systems 20/20 intervened at two levels. At the *community level*, the project worked through local implementing partners, Hindustan Latex Family Planning Promotion Trust and Swasth Foundation to build the capacity of four GRCs. Health Systems 20/20 showcased strategies to reinforce the health system for the poor: strengthening local level convergence processes; networking to create effective linkages to public and private sector providers to deliver services in a more accessible fashion; facilitating access to government-sponsored health insurance schemes; using demand-side mobilization to create awareness on key health issues and bring about behavioural change within the community; and enhancing GRCs' capacity to recognize and use community resources to address specific health issues of concern to the community. *At the Mission Convergence Program Management Unit level*, Health Systems 20/20 emphasized capacity building of the Program Management Unit to institutionalize piloted strategies. Specialized training programs equipped Program Managers with a greater knowledge of key health issues affecting poor urban communities as well as a more informed understanding of RSBY and other health insurance schemes. These technical competencies are important to increasing Managers' abilities to support and supervise GRC activities. Overall, Health Systems 20/20 encouraged Mission Convergence to support GRCs to take on a larger role in extending the public health system to the urban poor.

PROJECT IMPACT

Health Systems 20/20 used a twofold methodology to collect information on project impact. An end line survey completed in July 2012 captured data with which to conduct quantitative analyses of changes in health knowledge, behaviours and attitudes around use of health insurance and healthcare as well as trends in OOP health spending. The short duration of the pilot made it difficult to measure significant changes between baseline and end line data. Nonetheless, based on the analysis at the end line, awareness of health insurance programs improved between 2009 and 2012. In particular, data from household surveys showed a 16 percentage point increase in awareness of RSBY between baseline and end line (34% at baseline and 50% at endline). It also pointed to a 5% point increase in respondents who had heard about the Central Government Health Scheme (CGHS; 6% at baseline and 10% at end line) in the intervention GRCs' areas. Despite increased awareness of health insurance programs, however, data showed a decrease in enrolment in insurance schemes, in both control and intervention GRC areas. One explanation for the observed change in RSBY might be the persistent implementation roadblock of Third Party Administrators (TPAs) failing to reimburse empaneled hospitals in a timely manner. Hospitals consequently turned some RSBY cardholders away. Data may be indicating deterioration over time of consumer confidence in the scheme. Other positive results observed are increased utilization of key maternal health services between 2009 and 2010. A greater proportion of respondents had at least three or more antenatal (ANC) check-ups, and had delivered at either a government or private institution.

Augmenting the end line activity, the project also undertook a qualitative field research activity to obtain anecdotal evidence of project impact. Intensive focus groups were organized with important stakeholders in the pilot project including Mission Convergence staff, pilot GRCs, implementing partners and private service providers involved in extending

the continuity of care to urban slum dwellers. Focus groups reported greater GRC visibility within the communities as a result of piloted interventions. They also felt that GRCs' community mobilization strategies were more effective at improving access to and use of health-related services. Focus group participants also noted that educational aids helped GRCs carry out their community mobilization activities. They also felt that GRCs' networking with public and private health stakeholders resulted in a greater continuum of care being delivered during GRC-led health events.

LESSONS LEARNED FROM HEALTH SYSTEMS STRENGTHENING IN THE URBAN CONTEXT

- Effective implementation of financial risk protection for the poor is a complex issue requiring a multi-faceted approach to create the necessary enabling environment.
- Initial buy-in from Mission Convergence and highly active participation throughout the project was instrumental in the project's success.
- Health System's 20/20's flexible implementation plan left room for implementing partners and GRCs to innovate when needed in response to unforeseen priorities.
- Even projects aiming to make a difference at the implementation level must consider how high-level policies impact implementation.
- Setting targets for improved organizational performance is important to ensuring that health systems strengthening efforts create the requisite enabling environment to sustain improved health outcomes.
- Involving the private sector in health care for the poor is not just about communicating the population's unique needs; it is about helping the private sector to see opportunities to deliver services cost-effectively to a new market.

RECOMMENDATIONS FOR SUSTAINING AND SCALING-UP HEALTH INSURANCE FOR THE URBAN POOR IN INDIA

- Utilize process mapping to identify bottlenecks within the health system and the health insurance mechanism
- Align Mission Convergence human resource workforce skills with the programs coordinated under its umbrella
- Establish a robust monitoring and evaluation system to enable long-term tracking of how interventions impact health outcomes
- Rectify organizational relationship challenges between RSBY implementation stakeholders prior to moving ahead with RSBY scale-up
- Research the root causes of low enrolment in and use of health insurance by the urban poor so strategies to improve healthcare access are targeted and aligned to achieve health objectives
- Research value-for-money in healthcare service delivery to better target financing strategies for optimal return-on-investment
- Link health insurance efforts to other health programs to improve continuity of care among the urban poor and maximize investments
- Explore the potential for the Mission Convergence and other PPP models to be scaled-up more widely in Delhi and in Indian other states

1. INTRODUCTION

The Government of National Capital Territory of Delhi (GNCTD) sponsors a number of social welfare schemes that strive to improve the health and well-being of the poor. Health insurance schemes promoted by GNCTD aspire to extend financial risk protection against hospital expenses with the ultimate goal of reducing infant mortality, maternal mortality and out-of-pocket (OOP) expenditure on health.

Between 2009 and 2012, Health Systems 20/20, a global project funded by the United States Agency for International Development (USAID), provided technical assistance to the GNCTD Mission Convergence program with a dual aim. The project sought to facilitate greater access to health insurance and financial risk protection for the urban poor. It also endeavoured to extend the health system to hard-to-reach urban populations to meet their unique healthcare needs.

The project began with an informal process mapping exercise to identify opportunities, bottlenecks, and challenges that government-sponsored health insurances schemes face in delivering health insurance to poor and vulnerable populations. This was followed by a baseline survey of vulnerable households in Delhi slums to understand the unique circumstances, attitudes, behaviours, and needs of this population. Based on information gathered through these activities, Health Systems 20/20 designed a project results framework to guide strategies and activities.

This report describes the strategies and activities Health Systems 20/20 implemented, in collaboration with GNCTD, Mission Convergence, and a wide variety of other stakeholders. Health Systems 20/20 India activities sought to achieve the overarching goal of increasing utilization of government-sponsored health insurance by the poor to reduce OOP expenditures for healthcare and improve health outcomes. The project paid special attention to the problem of the covering the “last mile” — ensuring the health system includes strong mechanisms to extend access to insurance and health services at the community level. The document’s chapters are summarized below.

Chapter 2 presents the context that informed the design of Health Systems 20/20 strategies and interventions. The chapter first briefs the reader on the economic and population trends in India which have resulted in exceptional population growth in urban areas. The dangerous consequences of such growth are discussed, with specific emphasis on how those living in urban slums face increased risks for poor health. The chapter also reviews the numerous supply-side and demand-side determinants that interact and impact the poor’s access to quality, affordable, and appropriate health care. In particular, the chapter examines how high healthcare costs and weak access to financial risk protection such as health insurance constrain efforts to lift the poor out of poverty. The discussion then turns to the persistent challenges when implementing financial risk protection for the poor.

Chapter 3 presents a primer on the Mission Convergence program, including its impetus, mission and objectives, and key stakeholders. The chapter explores the program’s unique and innovative public-private partnership (PPP) approach to connecting vulnerable populations to government-sponsored programs. The chapter introduces Gender Resource Centres (GRCs), the critical, community-based outreach arm of Mission Convergence. GRCs serve as a “single-window”, where the poor can access all the information, support and welfare services they need, as well as referrals to other essential healthcare services. GRCs’ role in promoting access to government-sponsored health insurance is discussed,

along with the challenges these community-based organizations (CBOs) face in carrying out their mission. This chapter describes the rationale for Health System 20/20's collaboration with Mission Convergence and in particular with the GRCs.

The purpose of **Chapter 4** is to explore in depth the components of USAID technical assistance to Mission Convergence. The chapter describes the process mapping exercise and the project results framework. The framework stresses the potential within Mission Convergence's PPP model to bring health system actors closer together in order to enhance their collective ability to affect health outcomes in urban settings. The core strategies designed to operationalize the results framework are also presented in this chapter. These include:

- Strengthening health stakeholder coordination and networking to facilitate health insurance coverage
- Enhanced GRC activities to expand access to insurance and a continuum of healthcare
- Community mobilization, health awareness, and behaviour change
- Private sector engagement; and
- Institutionalization of Health Systems 20/20 strategies.

Chapter 5 presents both the quantitative and qualitative impacts of Health Systems 20/20 technical assistance. To measure program impact, the project supported both a final end line evaluation survey as well as focus group discussions with project stakeholders. Both activities aimed to understand the extent to which the pilot project was able to affect change.

Lastly, **Chapter 6** presents key lessons learned during the experience of implementing health systems strengthening activities in an urban environment. The report closes with a number of recommendations for sustaining the momentum and leveraging the successes achieved under this project, in order to continue to improve the health of the urban poor.

2. SNAPSHOT OF THE URBAN POOR AND HEALTHCARE ACCESS: AN EXAMINATION OF THE INDIAN HEALTH SYSTEM AND INSURANCE

2.1 SNAPSHOT OF THE URBAN POOR

Rapid urbanization in India is changing the face of and perceptions about who is poor and most vulnerable. The 2011 Census reported that the proportion of rural dwellers declined from 72.19% to 68.84% between 2001 and 2011. Out of India's total population of 1.21billion, approximately 833 million people now live in rural areas while 377 million inhabit urban areas (Directorate of Census Operations 2011). Decreasing employment opportunities in agriculture are driving migration of workers to seek jobs in cities, where higher job growth is happening (IRB and the World Bank 2011). Because these city jobs are often low-paying and outside the formal sector, India's rapid urban population growth has led to a simultaneous increase in urban poverty.

Around the world, unplanned and rapid urbanization accelerates the growth of urban slums, with severe consequences for those living there. The rising number of people quickly overburdens existing infrastructure and services such as water and sanitation, health facilities, housing, and schools. The result is large populations without access to basic services. Especially in degraded and crowded slum settings, the population's health suffers. Close living quarters accelerate the spread of airborne and waterborne illnesses such as acute respiratory infections (ARI), tuberculosis (TB), and diarrhoea. The World Health Organization asserts that slums and other vulnerable settlements are among the most life threatening environments because of the lack of basic infrastructure and services (WHO 1999).

In Delhi, the provisional population estimate from the 2011 Census is about 16.8 million, a 21% increase from the 2001 Census (Directorate of Census Operations 2011). At the 2001 census, Delhi's slum population was approximately 2 million people, or 19.6% of the total urban population for the state (NBO 2010). Although the 2011 Census estimate of slum inhabitants is not yet published, state actions during the decade to remove slums support initial assumptions that the slum population has decreased since 2001 (Directorate of Census Operations 2011). However, underreporting of slum inhabitant numbers is likely. The count may be affected by slums' substantial migrant populations, the omission of unlisted and undeclared slum areas, and the easy shift of populations between locations (MoHFW 2007).

The health risks posed to those living in a Delhi slum can be examined through the lens of maternal and child health indicators. Statistics show that poor women and children living in Delhi slums have worse health outcomes than non-poor urban women and children (IIPS 2010):

- Poor urban women are less likely than non-poor urban mothers to receive antenatal care (ANC) during pregnancy. Well below half of urban poor mothers (41%) receive the minimum 3 ANC visits compared with 82% from the urban non-poor.

- Only 17% of poor mothers give birth at a clinic or hospital where care for unforeseen delivery difficulties could be treated. This is compared with 71% of urban non-poor mothers.
- Poor urban families face the possibility that nearly one out of every two children born to them will die before his or her first birthday. Infant mortality for the urban poor is 55%, compared with only 38% for the urban non-poor.
- Poor children are at higher risk of not seeing their fifth birthday: under-5 mortality for the urban poor is 74%, compared with only 42% for the urban non-poor (UHRC 2006).

Many health indicators for the urban poor in Delhi are worse than those for the whole of India. Data suggest that living in urban slums is more detrimental to an individual's health than living in some of the poorest and most disenfranchised areas of India (MoHFW 2007).

The Ministry of Health and Family Welfare (MoHFW) explored the various factors that increase the urban poor's vulnerability to increased morbidity and mortality. The table below published by the Ministry succinctly lists the foremost factors contributing to health vulnerability in the urban slums.

TABLE 1: HEALTH VULNERABILITY FACTORS IN THE URBAN SLUMS

Factors	Situation Affecting Health Vulnerability in Slums
Economic conditions	Irregular employment, poor access to fair credit
Social conditions	Widespread alcoholism, gender inequity, poor educational status
Living environment	Poor access to safe water supply and sanitation facilities, overcrowding, poor housing and insecure land tenure
Access and use of public healthcare services	Lack of access to Integrated Child Development Services (ICDS) and primary healthcare services, poor quality of healthcare
Hidden / Unlisted slums	Many slums are not notified in official records and remain outside the purview of civic and health services
Rapid mobility	Temporary migrants denied access to health services and other development programmes, difficulty in
Health and disease	tracking and providing follow-up health services to recent migrants
Negotiating capacity	High prevalence of diarrhoea, fever and cough among children
Economic conditions	Lack of organized community collective efforts in slums
Social conditions	Irregular employment, poor access to fair credit
Living environment	Widespread alcoholism, gender inequity, poor educational status

Source: MoHFW 2007

Vulnerability in urban settings like Delhi is the product of numerous factors. Economics, however, plays a significant role. The population's overwhelming reliance on low-paid informal sector work comes with a high price. Unreliable income makes amassing wealth impossible. Even a brief disruption in a family's income resulting from personal illness or other shock event can send a poor family into an economic crisis. Existing resources are redirected to deal with the shock, and no new income is earned to cover everyday living expenses. The pattern of low income, low financial stability, and high health risk among the urban poor can plunge a family deeper into poverty with each subsequent financial shock. Recovery from financial debts is difficult.

2.2 DETERMINANTS OF HEALTH AMONG THE URBAN POOR

Numerous demand-side and supply-side factors affect the extent to which the urban poor access and use available financial risk protections and health services. The interaction between these factors is as significant as the factors themselves: challenges on the supply side contribute to reduction in demand. These factors, and the relationships between them,

were carefully examined to inform the design and implementation of Health Systems 20/20 strategies.

2.2.1 SUPPLY-SIDE DETERMINANTS

Supply-side determinants of health refer to the factors which affect how and to what extent health services and information reach their intended beneficiaries in the urban slums. All elements of the health system — from the cost of services, financial risk protection, quality of care and available medicines, and linkages to referral networks and medical treatment options — impact how successfully healthcare is supplied to the urban poor.

Cost of Care and Out-of-Pocket Expenditures In general, India is shown to have a high level of OOP expenditure by individuals: in 2009 OOP expenses were 74.39% of total health expenditure. For 21% of Indian households, spending on healthcare was more than 15% of total household consumption. A 2009 study on the impact of OOP on overall household consumption revealed that slum dwellers spend on average a much larger share of their consumption budget on healthcare (14%) than those from the non-slums (9%). This underscores an important point: in India the poor pay more than the non-poor for healthcare (Alam and Tyagi 2009).

Cost of medicine is a substantial portion of OOP spending; more than three-fourths of the money spent on health is going to modern medicines. Recent research also indicates that the poor's reliance on private sector providers, who generally charge higher fees, is a substantial factor driving up OOP healthcare costs in India. Poor performance of public sector health services has prompted more patients to seek out private providers, even when it means shouldering a higher burden of OOP expenses (Alam and Tyagi 2009). This, in turn, creates additional cost barriers to accessing care.

Table 2 breaks down healthcare expenses paid by baseline respondents for most recent out-patient department (OPD) treatment. The data shows that the average expenditure at a private facility is much higher than expenditures at a Government facility or with an unlicensed practitioner. Also noted is that the cost of medicine account for 68% of total health expenditures.

TABLE 2: ITEMIZED HEALTH EXPENDITURES BY BASELINE RESPONDENTS

Expenditure Type	Overall Cost (n=432)		Government Facility (n=137)		Private Facility (n=170)		Unlicensed Medical Practitioners (n=125)	
Doctor's Fees	63	(13%)	8	(2%)	145	(19%)	13	(6%)
Medicines	340	(68%)	318	(79%)	459	(59%)	187	(87%)
Investigations	42	(9%)	8	(2%)	99	(13%)	4	(2%)
Transport & Others	49	(10%)	69	(17%)	70	(9%)	11	(5%)
Total	494	(100%)	403	(100%)	773	(100%)	214	(100%)

Access to and Use of Appropriate Health Insurance Health insurance can improve financial access to healthcare services by reducing OOP at the point of service. It can also have positive impacts on other elements of the health system that drive access to care, including: strengthening the referral network, creating incentives to improve quality of care, and mobilizing providers to be available in health facilities.

Health insurance for the poor and vulnerable in India is a relatively recent development. Prior to 2001, the poor faced prohibitively high OOP costs at the point of service, even in the

public sector, where services were lower costs than in the private sector. Health insurance took its greatest leap after the success of *Yeshasvini*, the insurance policy launched in 2002 by the State Government of Karnataka for the Co-operative sector. Encouraged by the success of Yeshasvini, the Andhra Pradesh Government in 2007 launched *Rajiv Aarogyasri*, a critical illness policy for the poor with a benefits package that includes 942 surgical procedures and 144 medical diseases. *Rashtriya Swasthya Bima Yojana (*RSBY), the scheme on which the Health Systems 20/20 project focused, was conceptualized and developed by the MoHFW in 2008 for families below the poverty line (BPL). Under RSBY, 75% of the insurance premium is subsidised by the Central Government and the remainder paid by State Governments. The percentage of central subsidy goes up to 90% for the State of Jammu and Kashmir and the North-Eastern States. Over a period of 3 years, RSBY has become the flagship health insurance scheme for the poor in India. The number of individuals covered under the scheme has steadily grown to over 189 million in 2001 (IRDA 2011).

Presently in India, health insurance schemes for the poor and vulnerable collectively reach around 200 million people and target all 350-400 million BPL beneficiaries. While characteristics vary across these schemes, one notable similarity stands out: none of the schemes cover primary or preventive healthcare services. These are the most common services needed by the poor. The lack of insurance coverage for these services means that poor families must either pay out-of-pocket for those services, or do without them. The poor's lack of access to health insurance covering their most common ailments limits their ability to access the services they need and negatively impacts their well-being.

It is important to note, however, that insurance availability alone does not equal access and use. Health Systems 20/20 found that Delhi's slum dwellers have low awareness and utilization of insurance schemes. Compelling data from the Health Systems 20/20 baseline survey reported that only 34% of families living at the poverty line (APL) and below from the GRC areas in which Health Systems 20/20 planned to work had heard of RSBY. Registration in the scheme was even lower, only 8% of respondents.

Table 3 presents a similar situation for awareness and registration of other insurance schemes. Only a small fraction of respondents were registered in the Employee State Insurance Scheme (ESIS) (5%), and even fewer in the Central Government Health Scheme (CGHS) (1.4%), Mediclaim (0.7%), and RSBY (0.1%). These data demonstrate that the potential for health insurance to improve the financial security of the poor is undermined by the failure of the health system to adequately inform and motivate the poor to use it.

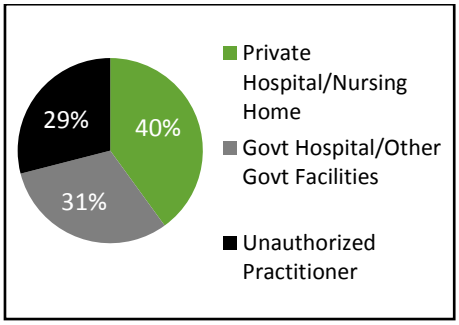
TABLE 3: BASELINE RESPONDENTS' AWARENESS OF AND REGISTRATION IN OTHER INSURANCE SCHEMES (N=1619)

Status	ESIS	CGHS	Mediclaim	RSBY
Aware	21%	6%	%	1%
Registered	5% (79)	1.4% (22)	0.7% (12)	0.1% (1)

Quality of Care The Government of India has acknowledged that public primary healthcare facilities in urban areas are frequently unavailable and substantially underutilized. At the same time, secondary and tertiary care centres are overcrowded. The National Health Policy-2002 articulates setting up a two-tier Urban Primary Health Care structure in response (MoHFW 2007). As this structure is being built, however, current healthcare resources are insufficient to provide high quality care that meets the overwhelming demand. Budgets fall short of the resources to both maintain fully modernized facilities and regularly update staff technical and interpersonal skills to better cater to the unique needs of the urban population.

As noted previously, lower quality of care at public facilities has prompted the poor to increasingly seek healthcare services outside the public system. The Health Systems 20/20 baseline survey found that nearly two-thirds of survey respondents used private hospitals or unlicensed medical practitioners for their most recent OPD treatments (see Chart 1). Households reported four primary reasons for not using a government health facility: long wait time; non-availability of medicines; bad behaviour of hospital staff; and facility distance from place of residence. When services are delivered poorly or viewed to be of low quality, it is no surprise that facilities fail to attract higher use. However, the growing preference for non-public providers comes at the risk of financial loss and continued poor health among APL and BPL populations.

CHART 1: OPD TREATMENT LOCATION FOR BASELINE RESPONDENTS' MOST RECENT ILLNESS (N=432)



Operational access constraints In the Delhi urban slum areas, access to healthcare is influenced in large part by operational issues. Health Systems 20/20 found that poor linkages and weak referral networks between community agents and health facilities serving the urban poor inhibit continuity of care. For example, the baseline survey showed that government outreach workers such as Auxiliary Nurse Midwives (ANM) and Accredited Social Health Activists (ASHA) are viewed by respondents as regular sources of information about maternal and reproductive health. Yet ASHA visits were reported by less than half of the respondents, an average of 45%, and ANM visits averaged only slightly higher at 65%. The inability of this network of community-centred providers to reach more beneficiaries and provide potentially life-changing information and referrals counselling is an operational barrier to be overcome. This barrier also means that opportunities are missed for community-level providers to share information about slum dwellers' needs and join forces to deliver a better level of care.

2.2.2 DEMAND-SIDE DETERMINANTS

The demand-side determinants of health refer to the factors which affect individuals' attitudes, perceptions, and behaviours. These factors impact how and to what extent people demand, seek out and utilize health information and services. It is the interaction of economic, social, and environmental factors in urban slums that produces generally poorer health outcomes than non-poor, urban dwellers and inhabitants of rural areas.

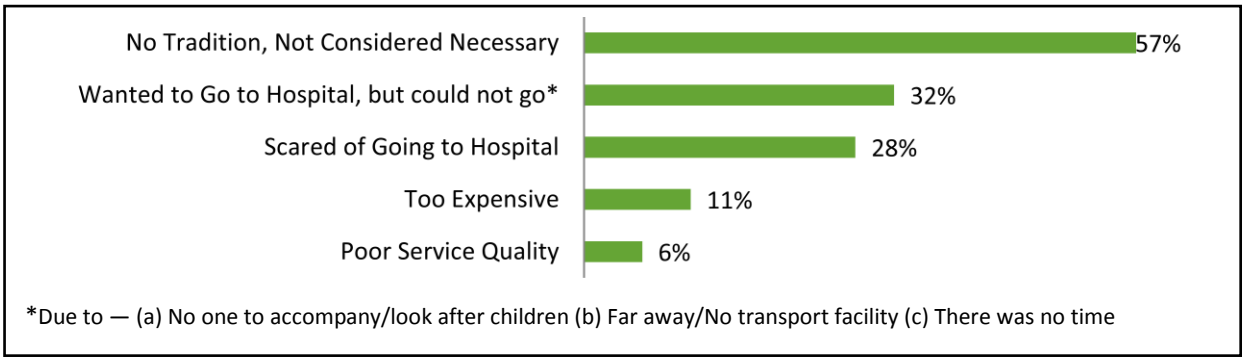
Physical Mobility In general, people living in urban slums are young, uneducated, physically mobile, and underemployed. This mobility and the possibility of being separated from family create an environment of higher susceptibility to health risks. The spread of HIV is easier when families are separated and people have the opportunity to engage in high-risk sexual relations. Communicable diseases spread easily in densely-populated urban slums. A lack of sanitation infrastructure, including sewers and piped clean water, means waterborne illnesses and respiratory infections are easily passed when people share cramped rooms and food and water are prepared in insanitary conditions. Preventable disease outbreaks affecting children (e.g., TB, diphtheria, pertussis, tetanus, polio and measles) are more likely

to occur in the urban slums due to lack of immunization, rapid migration, and overcrowding (MoHFW 2007).

Knowledge, Attitudes and Behaviours Knowledge, attitudes and behaviours regarding health are also demand-side determinants of health. These determinants are shaped by educational, societal, and cultural factors. Baseline data in the Health Systems 20/20 intervention slums showed that 23% of survey respondents were illiterate while another 34% had only completed primary schooling. Such low educational levels among the poor mean that solely written information shared about available health services, financial risk protections, and educational and legal support services may miss its intended audience.

Cultural norms engrained within Scheduled Castes/Scheduled Tribes (SC/ST) and other backward castes (OBC) often drive healthcare behaviours and decisions. For example, baseline data indicated that just over half of SC/ST and OBC pregnant women deliver their babies in a healthcare institution (52% and 54%, respectively). As illustrated in Chart 2, the majority of responding mothers (57%) who delivered at an institutional facility considered it against tradition and unnecessary to change. Successfully promoting healthy behaviours, such as institutional deliveries, breastfeeding, and adherence to child vaccination schedules, may require changing cultural norms.

CHART 2: REASONS THAT PREGNANT WOMEN DECIDE NOT TO DELIVER THEIR BABIES AT AN INSTITUTIONAL FACILITY



*Due to — (a) No one to accompany/look after children (b) Far away/No transport facility (c) There was no time

Perceived Cost of Services Healthcare costs, or the perceived costs, are often a major concern that prevents people from accessing care. For households or individuals with limited disposable income, the costs associated with accessing care figure significantly in their choice of when and how often to seek care. Those living at or below the poverty line must make difficult choices every day on how to spend their meagre income. They may view OOP healthcare costs, or costs required at the time of service, as being prohibitively expensive — even for primary healthcare needs.

2.3 CHALLENGES TO IMPLEMENTING FINANCIAL RISK PROTECTION FOR THE POOR

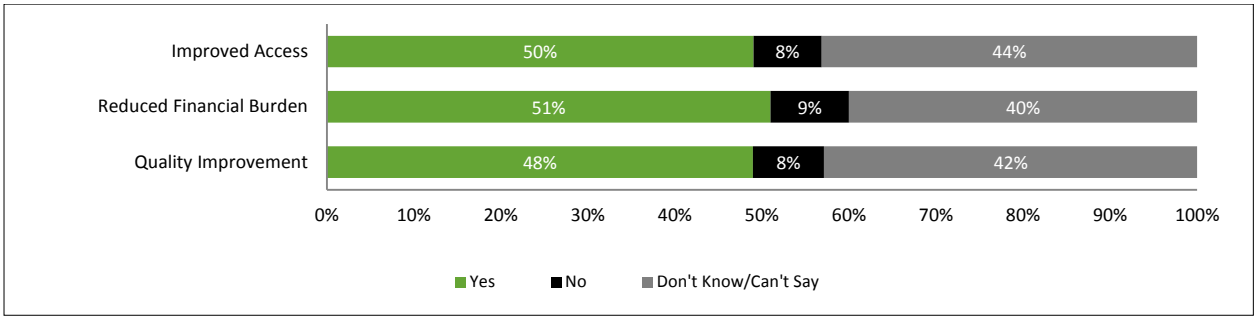
The unique characteristics of the urban poor — common health threats, cultural profile, economic status, education, mobility, housing situation — require special consideration in the design and implementation of financial risk protection schemes. The numerous government-sponsored health insurances schemes for BPL families emerging in recent years are laudable for recognizing the need to reduce the poor's high OOP healthcare expenses. However, they have not achieved maximum effectiveness. For example, while examining the systems supporting RSBY implementation, Health Systems 20/20 found that operational and implementation flaws compromise the ability the Delhi government to reach its intended beneficiaries for health insurance. The discussion which follows examines each issue in turn, using RSBY as a point of departure. In doing so, a clearer picture is painted of the missing elements within current government systems for extending access to health insurance and services to the poor.

Limited Coverage and Benefits Like most health insurance schemes in India, RSBY focuses on in-patient care. The benefit package is designed to mainly cover in-patient secondary care at empanelled hospitals. A limitation of RSBY design is the annual benefit cap of Rs. 30,000, which automatically precludes any tertiary level coverage. Further, primary care expenses are not included in the RSBY benefit package. Yet primary care expenses are among the major components of OOP expenditures for healthcare. An average of only 3.1% of the urban population is hospitalized at any given point of time. Yet, 9.9% of the population accesses outpatient coverage (NSSO 2006). The baseline revealed that a significant proportion of households in both the intervention and control GRCs reported experiencing chronic illnesses: 34% in the proposed intervention and 39% in the control GRCs. Spending on outpatient care — per capita spending and share of total OOP expenditure and overall household expenses — far outstrips spending for inpatient care expenditure. In light of this reality, outpatient care matters a great deal in India (Selvaraj and Karan 2012).

Currently available schemes ignore the types of ailments to which the urban poor are most susceptible. ARI, TB and other communicable diseases, waterborne illnesses, and pregnancy complications are excluded from insurance benefit packages. Preventative care is also completely excluded. Hospital care, however, is included. This means that a patient benefits from insurance schemes only when he or she is sick enough to be hospitalized. This has important financial and health implications. Early access to screening and treatment for preventable conditions and communicable diseases could avoid the need for more expensive secondary or tertiary care. Early treatment would also lower the contagion risk to other family and community members living in close proximity. Because current benefit designs disregard the context in which the urban poor live, they contribute to the spread of diseases and lead to the poor paying for what could be avoidable healthcare costs.

Inattention to Demand-Creation A false assumption of health insurance scheme designers and administrators is that the poor understand the value of health insurance and therefore want to enrol. The Health Systems 20/20 baseline survey showed that awareness of and registration in RSBY are low. In addition, only half of those enrolled perceived a benefit, such as improved access to services, reduced financial burden, and improved quality of service delivery. Chart 3 shows that many respondents are not yet convinced of the benefits of the scheme and cannot articulate any benefits of enrolling.

CHART 3: PERCEPTION OF REGISTERED HOUSEHOLDS ON THE BENEFITS OF RSBY (N=129)



The lack of awareness and perceived benefit may be due, in part, to the way the enrolment has historically been managed. Prior to Health Systems 20/20's work, Third Party Administrators (TPAs) generally handled enrolment. These groups had limited connections and relationships to the community, and rarely coordinated with GRCs or other community groups that could assist with mobilizing target populations to enrol. As a result, the timing of enrolment and benefits of becoming a RSBY cardholder were not effectively communicated to potential beneficiaries, and fewer enrolled.

Absence of Service Delivery Quality Standards In India, the lack of service delivery quality standards is negatively impacting health insurance utilization. Under RSBY, for example, TPAs have not established quality standards that hospitals must meet and report on in order to be empaneled. Empanelment is based on number of beds available and ability to perform certain procedures, rather than qualified staff, adequate supplies, or evidence of good health outcomes. Presently, most private hospitals empanelled under RSBY are small or medium-sized hospitals and nursing homes. These types of hospitals have fewer resources to provide high quality services and barely meet the minimum empanelment criterion.

TPAs formalize agreements to reimburse hospitals based on the number of patients treated. Registered beneficiaries are directed to empaneled hospitals for in-patient care, and hospitals are reimbursed on a per capita basis. Thus, despite under qualified staff and only basic supplies, and regardless of the quality of care and actual patient outcomes, empaneled hospitals are able to receive full reimbursement for RSBY patients. The absence of guidelines often perpetuates low service quality in facilities serving the urban poor. This, in turn, contributes to the urban poor's low use of empaneled hospitals services and their decisions to seek care elsewhere despite the additional financial expense.

After three years of successful operation, RSBY has identified important shortcomings of the scheme and is ushering in quality consciousness. RSBY is engaging the National Board for Accreditation of Hospitals and Healthcare Providers (NABH) to evaluate and establish measurable quality indices for empaneled hospitals. The challenge, however, is to develop standards and accreditation processes that are affordable for smaller hospitals, along with mechanisms to encourage and incentivize accreditation.

While few RSBY empaneled hospitals report on the quality of their services, even fewer have processes to gauge patient satisfaction and health outcomes. These are important to creating a culture of quality improvement at healthcare facilities. Yet the implementation systems for health insurance lack robust monitoring and evaluation of beneficiary satisfaction. The nature and culture of poor beneficiaries present additional challenges. Patients' low literacy levels, limited awareness of their rights and powers as healthcare consumers, and low levels of personal empowerment make it difficult for hospitals to solicit

and obtain patients' honest feedback on the quality of services. This highlights the need to develop culturally appropriate processes to engage beneficiaries in the quality improvement process without negative repercussions from providers.

Prospects for Scalability and Long-Term Sustainability Like other mass-based insurance schemes, RSBY is almost entirely funded by the central and State Governments. Seventy-five per cent of the RSBY insurance premium is absorbed by the Government of India; the balance is paid by the implementing state. Beneficiaries only pay a token amount of Rs. 30 per family towards registration charges. The central and State Governments plan to universally scale-up schemes to qualified beneficiaries, and the Planning Commission-appointed High Level Expert Group (HLEG) has recommended Universal Health Coverage (UHC) for the entire population on the pattern of RSBY. Continuous and significant Government contributions will be required to scale up RSBY and other popular schemes for the poor. This has broad implications for the long-term funding and sustainability of these schemes; financial models must be in place to support further scale-up of the package.

3. STREAMLING SOCIAL BENEFITS TO THE URBAN POOR: DELHI'S MISSION CONVERGENCE

3.1 MISSION AND OBJECTIVES

Mission Convergence is a product of enlightened thinking by the GNCTD about how best to implement social sector programs to improve the quality of life the most vulnerable and disadvantaged sections of society. By 2008, the GNCTD recognized that social support initiatives delivered separately across nine departments[1] had created a complicated and often inefficient system, with implementing agents often duplicating efforts. The lack of a central point of contact within the community diminished the reach of all welfare programs. It was unclear to what extent any program was closing the "last mile" gap — i.e., how well the public welfare program was actually delivering services to intended beneficiaries. It was also difficult to track which services individual beneficiaries accessed.

To overcome these obstacles, GNCTD visualized the Mission Convergence program as a common platform for providing social welfare entitlements to poor and marginalized populations of Delhi. The Mission Convergence model is a PPP to extend welfare services to communities. Successful implementation of the program will achieve the following objectives:

- Increase the visibility of welfare schemes among targeted communities
- Enhance beneficiaries' control and influence over the welfare schemes
- Strengthen delivery organizations including GRCs, nongovernmental organizations (NGOs) and Government line departments and their processes to prompt service delivery
- Incentivize and reinforce appropriate mechanisms for beneficiaries to access services and for service providers to deliver services.[2]

[1] The nine departments are: Health and Family Welfare, Food and Civil Supplies, SC/ST/OBC and Minorities Welfare, Social Welfare, Urban Development, Labour, and Information Technology

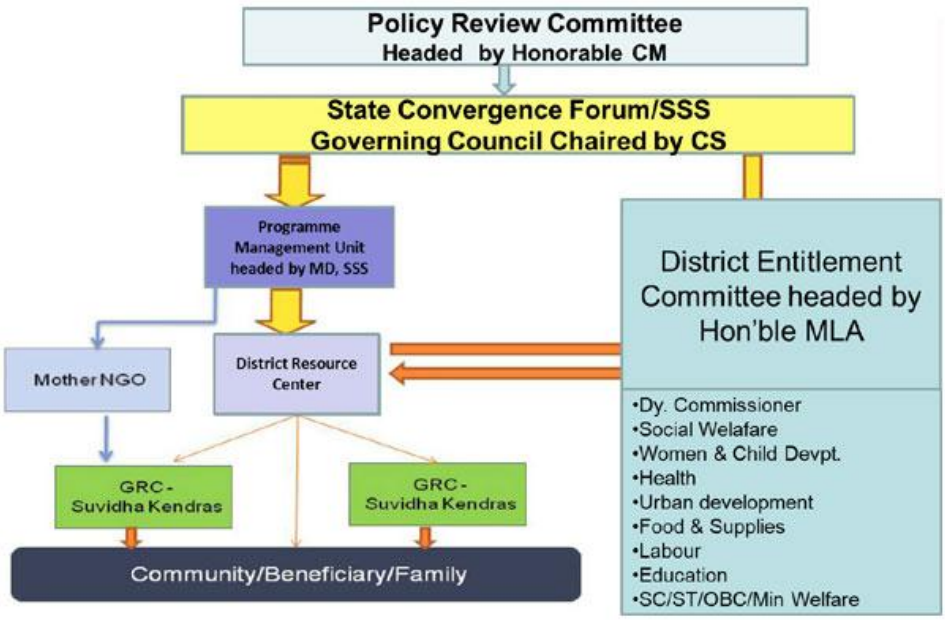
[2] Mission Convergence Website. http://delhi.gov.in/wps/wcm/connect/doit_mc/DoIT_MC/Home/. Accessed June 13, 2012.

3.2 INSTITUTIONAL STRUCTURE

Figure 1 illustrates the structure of Mission Convergence and the relationship between various units within the program. Mission Convergence strives to strengthen the implementation machinery at the lower levels of the health systems by integrating CBOs as partners in the process. *Stree Suvidha Kendras* (SSKs; translated: Gender Resource Centres or GRCs) are CBOs located in slum communities that have been selected by Mission Convergence. They are the primary implementation unit of the Mission Convergence mandate. Each GRC caters to a population of 20,000 households; as of 2012, 104 GRCs are located throughout Delhi's nine districts.

GRCs forward beneficiary requests to their District Resource Centre (DRC) and District Management Unit (DMU). These entities coordinate the work of GRCs in their respective districts. DRCs and DMUs forward the request to the appropriate departments in the District Entitlement Committee. The Mission Convergence program has designated four technical support units called Mother NGOs to build the capacity of GRCs on various program specific issues, as well as monitor and supervise GRCs' activities. Both Mother NGOs and DRCs are supervised by the Mission Convergence Program Management Unit (PMU). Subject specialists and program managers within the PMU are responsible for coordinating with line departments on policy decisions as well as providing oversight and technical support to ensure program effectiveness.

FIGURE 1: MISSION CONVERGENCE INSTITUTIONAL STRUCTURE

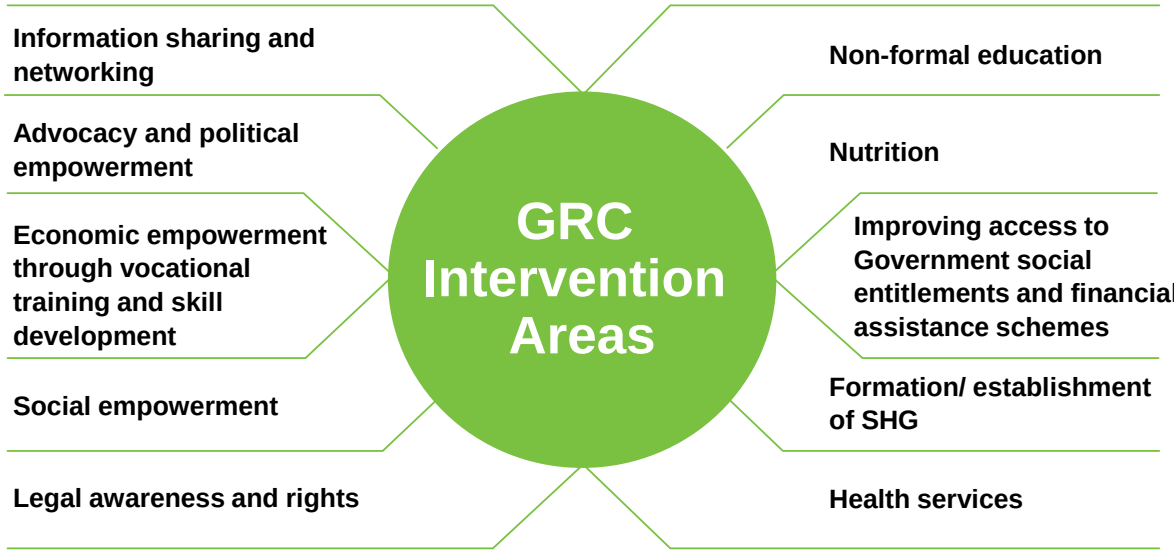


Source: Mission Convergence Website. http://www.missionconvergence.org/institutional-structure.html

3.3 CHALLENGES AND OPPORTUNITIES

The Mission Convergence Program envisions an active and central role for GRCs. GRCs are expected to carry out broad household and individual well-being improvement activities, such as those presented in Figure 2. GRCs interact with the community through group meetings, campaigns, and door-to-door contact. They gather information about beneficiary needs and guide families to access government welfare and healthcare services. Their target population includes women, adolescents, the elderly, disabled and other disadvantaged groups living in slums and low income housing, as well as the homeless.

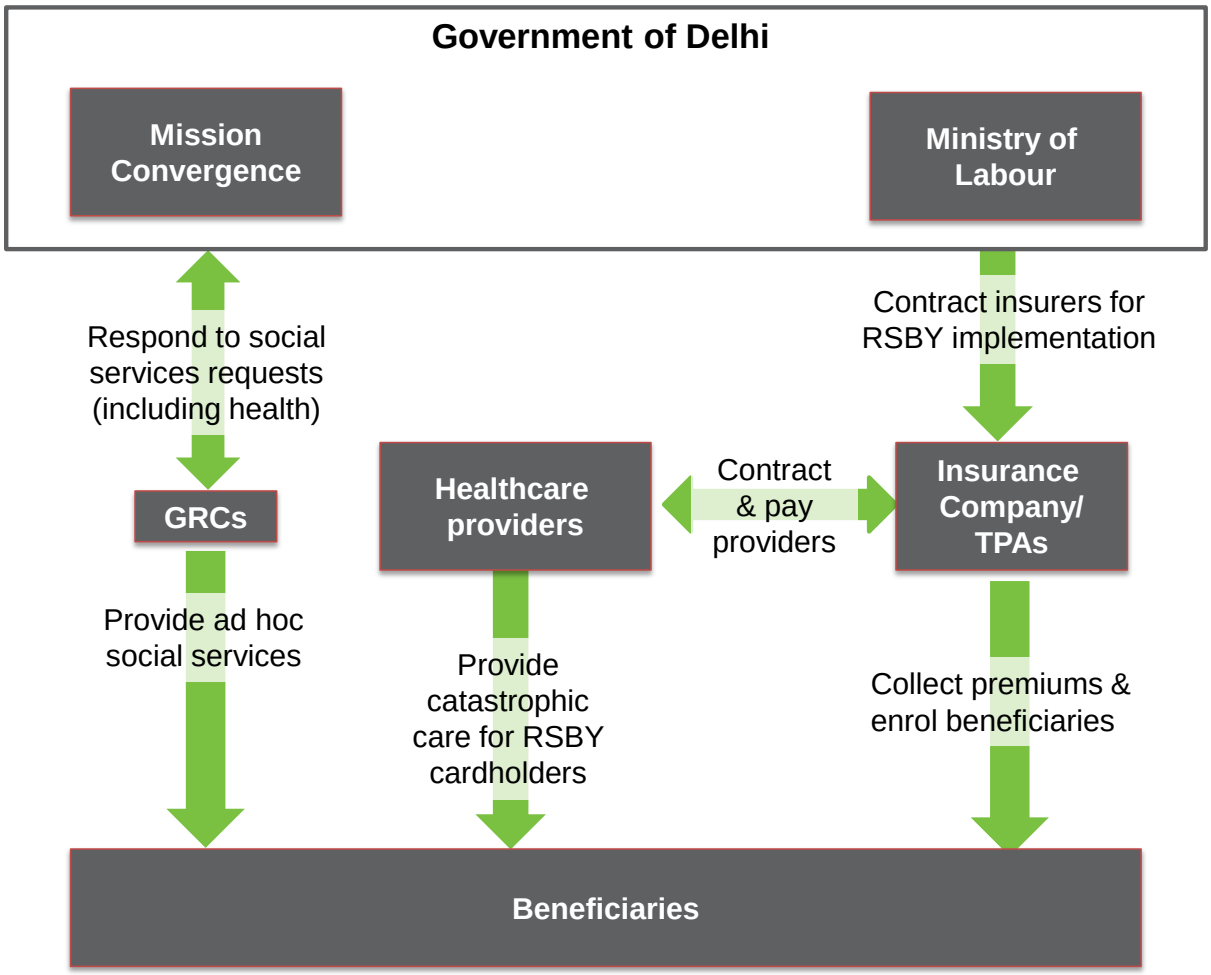
FIGURE 2: GRC INTERVENTION AREAS



Because they are located in communities and have relationships with community members, the GRC network is intended to be the conduit through which health insurance and other social welfare schemes are extended to the urban poor. For example, prior to RSBY enrolment, GRCs are tasked with informing community members about the benefits of the scheme and the registration process. Enrolment of RSBY beneficiaries should be facilitated by GRCs at their centres or other community locations. If deputed by the Department of Labour (DoL), GRC Coordinators may play the role of Field Key Officers (FKOs) during the enrolment period, authenticating RSBY cards and the family members listed on them. Outside enrolment, GRCs are expected to organize health camps and clinics on a regular basis. When necessary, they also refer community members for treatment at empaneled hospitals or other providers. It is the responsibility of GRCs to develop relationships with empanelled hospitals to be able to fulfil this referral role.

At the start of the project, Health Systems 20/20 and Mission Convergence stakeholders conducted an informal mapping exercise to examine the implementation of RSBY. The purpose was to understand how the envisioned system was actually operating in reality, and identify bottlenecks and opportunities within the system. Figure 3 presents the results of this exercise, indicating relationships between actors and primary roles carried out.

FIGURE 3: MISSION CONVERGENCE RSBY IMPLEMENTATION PRE-HEALTH SYSTEMS 20/20



Through the mapping exercise, participants recognized a key challenge: GRCs were not consistently able to implement their full role. While GRCs acted as the clearinghouse to help beneficiaries access government health and welfare programs, their activities were mostly carried out independently of the other actors within the health system. Private facilities, NGOs, primary health centres (PHC) and other public health agencies rarely participated in GRC activities such as health camps and community outreach events. Furthermore, low GRC technical capacity in health programming and program management limited their ability to mobilize the community around financial risk protection programs. Health insurance agencies and TPAs still bore the largest responsibility for RSBY enrolment. However, neither of these entities had strong community ties that they could leverage to promote enrolment. TPAs went into the community to sign up new families, but the outreach process was slow and they often fell short of RSBY enrolment targets. Limited capacity and lack of collaboration between stakeholder groups resulted in less than optimal access to and use of health insurance and healthcare services by the poor.

4. STRATEGIC USAID ASSISTANCE TO DELHI'S MISSION CONVERGENCE: STRENGTHENING HEALTH SYSTEMS TO REACH THE URBAN POOR

In mid-2010, Health Systems 20/20 commenced in earnest technical assistance to Mission Convergence and its GRC network. Information gathered during the informal process mapping exercise and the baseline survey underpinned the design of technical strategies to overcome health insurance implementation bottlenecks as well as improve access to healthcare.

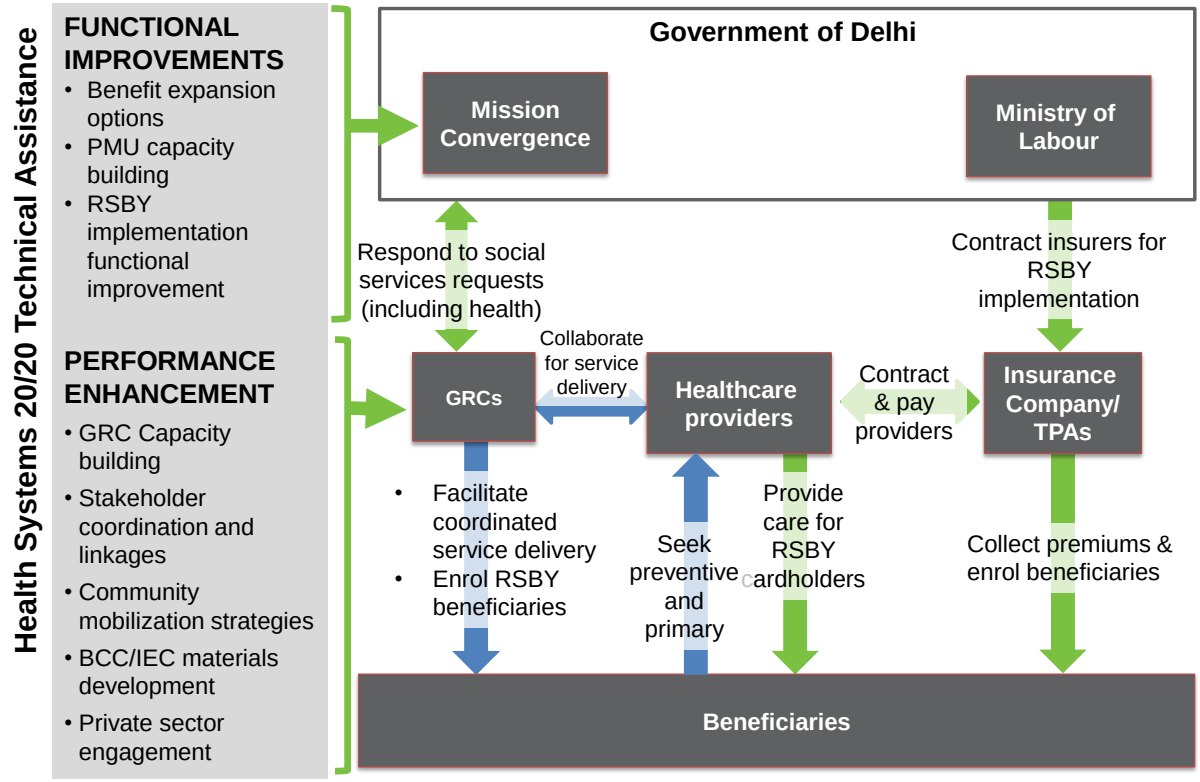
The Health Systems 20/20 and Mission Convergence team recognized that any activity implemented in the urban slums needs to be flexible and responsive to the special circumstances of these communities. The project also appreciated GRCs as a critical pillar of the health system for the urban poor. GRCs are a social and institutional asset: they have an excellent foothold in the community and the ability to collect information about the communities' health priorities. In order to leverage these assets, Health Systems 20/20 worked with the Mission Convergence PMU to design and implement functional improvements in how RSBY enrolment occurred in the community. This involved integrated, complementary community-based activities that reinforced GRCs' responsibilities for facilitating access to government welfare programs. Strategies also stressed establishing strong partnerships among health system actors, with Mission Convergence and GRCs assuming an important leadership role, especially at the community level. In order to support these changes and increase likelihood that improvements are sustained, Health Systems 20/20 strengthened the capacity of the PMU to oversee and support to GRCs, and institutionalize program activities.

Figure 4 presents the technical assistance activities implemented by Health Systems 20/20 (left side of figure) and illustrates stakeholders' roles and relationship in the RSBY implementation process after Health Systems 20/20 technical assistance. Health Systems 20/20 technical assistance activities to the Mission Convergence PMU and GRCs sought to improve their collective ability to:

- Assist households to enrol in and use government health insurance programs, such as RSBY, *Janani Suraksha Yojana* (JSY; translated: Safe Motherhood Scheme), and MAMTA (translated: affection) in order to access free tertiary care in private specialty hospitals with the goal of reducing OOP expenses borne by the poor for healthcare;
- Guide poor households to access the public health system and deter their dependence on unlicensed medical practitioners;

- Facilitate continuity of care by working to expand primary and preventive healthcare, in addition to insurance coverage, by supporting behaviour change communication (BCC) programs through the development of targeted educational materials covering maternal and child health (MCH), HIV/AIDS, nutrition, and other health topics as well as materials to promote RSBY enrolment.

FIGURE 4: MISSION CONVERGENCE RSBY IMPLEMENTATION POST-HEALTH SYSTEMS 20/20



4.1 HEALTH SYSTEMS 20/20 RESULTS FRAMEWORK

For a period of 11 months, the project worked with four GRCs — MANCH, Dr. A.V. Baliga Memorial Trust, Datamation Foundation Charitable Trust, and Mahila Vikas Sansthan (MVS) — as intervention sites to pilot strategies to improve how the poor access and utilize better health services. These strategies also aimed to increase the poor's awareness of important health issues and encourage them to practice preventive and early care. Mission Convergence Program Managers were also singled out for specialized support, given their responsibilities for overseeing the GRCs' work and monitoring RSBY implementation. The Project Results Framework (Table 4) depicts the linkage between the project's overall goal focused on reducing OOP expenditures and improving health outcomes among the poor and the individual strategies employed during the pilot project. It also presents the program inputs applied to reach each project objective.

TABLE 4: HEALTH SYSTEMS 20/20 RESULTS FRAMEWORK

Program Goal
Increase utilization of government-sponsored health insurance by the poor to reduce out-of-pocket expenditures for health care and improve health outcomes

Objectives

1. Build capacity within local organizations (in both staff skills and organizational structure) to ensure the right institutional and staffing framework exists to execute the health insurance program
2. Strengthen skills within the PMU to effectively supervise and support GRCs to implement the health program and expand access to and use of RSBY
3. Increase communities' ability to access primary and secondary healthcare services by facilitating networking with private providers to deliver health services at the community level

Inputs	Outputs	Outcomes	Desired Impact
• Health programs consolidation • Coordination of Ministry, NGOs, and private sector to extend continuity of care • GRC capacity building • Public health education, mobilization • Institutionalization of Health System 20/20 strategies through program management training • Health information management	• Improved capacity of GRCs to promote health benefit schemes and increase enrolment/ coverage • Improved access to health entitlements, particularly by poor and vulnerable households	• Increased awareness of government-supported health programs (NRHM, JSY, GRC) • Increased awareness of health insurance (including RSBY) • Increased awareness of maternal health services available • Increased health benefit coverage (including enrolment in RSBY and other health programs) • Community empowerment of poor/vulnerable slum dwellers	• Reduced out-of-pocket healthcare expenses • Increased utilization of formal healthcare services • Increased utilization of maternal health care • Increased utilization of child health care

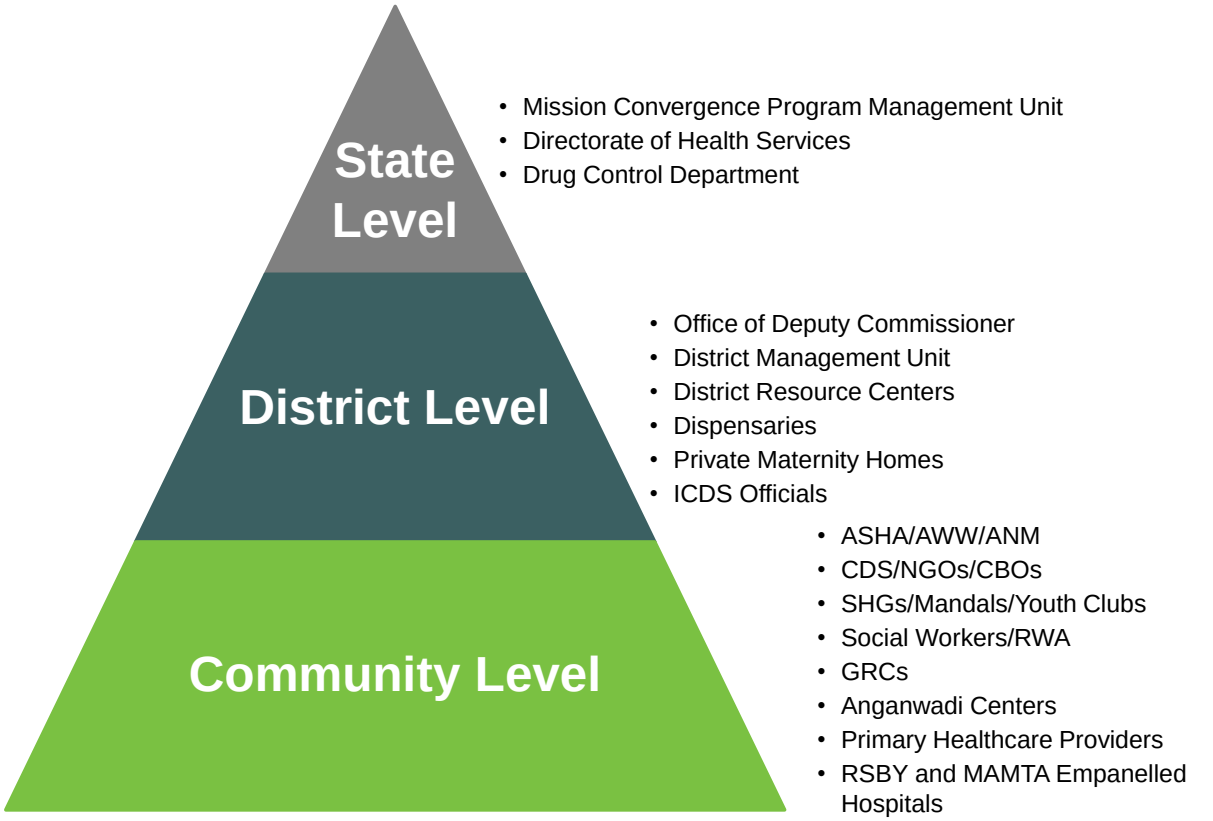
4.2 COMPONENTS OF TECHNICAL ASSISTANCE

4.2.1 STRENGTHENING STAKEHOLDER COORDINATION AND NETWORKING TO FACILITATE INSURANCE COVERAGE

Mission Convergence's objective of integrating the welfare programs delivered by nine different government departments must surmount the logistical challenges inherent in working with diverse stakeholders (see Figure 5). State, District, and community level entities in the government's health system are accountable to one of the nine departments.

However, there was no mechanism in place to help coordination and collaboration across these departments.

FIGURE 5: KEY STAKEHOLDERS IN THE GNCTD HEALTH SYSTEM



Health Systems 20/20 helped bring greater efficiency to the Mission Convergence program by emphasizing networking and linkages as a core strategy. Taken together, Health Systems 20/20 networking and linkages strategies frame a PPP model to address health program implementation challenges and fill service delivery gaps. This bottom-up model improved access and utilization of primary healthcare services by knitting key public and private stakeholders together to produce more coordinated and more effective health programs.

Under the banner of the Health Systems 20/20 networking strategy, regular coordination workshops and meetings created forums for increasing awareness about Mission Convergence and individual entities' role in improving access and use of health services by vulnerable populations. The pilot project achieved initial important buy-in from District Level through a well-executed orientation workshop. Then, it helped revamp the format and substance of the monthly District Convergence Forum. A wider range of Government and community-based entities were included so that all stakeholders could exchange information about upcoming health activities and emerging priorities to promote collaboration.

Linkages with Government agents

Linkages with Government entities extended to all involved in healthcare delivery and promotion activities in the urban slums: PHCs; Delhi Government Dispensaries (DGD); the National Rural Health Mission (NRHM) District cell; ICDS supervisors; and health functionaries such as ANM, *Anganwadi* Workers (AWW), and ASHA. Coordination meetings permitted sharing about different activities and, most importantly, enabled health staff and functionaries to identify weaknesses or gaps in activities that could be filled through

collaboration. For instance, at one meeting stakeholders mapped out and produced a comprehensive list of health facilities/services in their area as well as community Depot Holders of family planning products.

District level involvement in community mobilization efforts particularly benefitted from the networking facilitated by Health Systems 20/20 implementing partners, Hindustan Latex Family Planning Promotion Trust (HLFPPT) and Swasth Foundation. Implementing partners met with ICDS and as a result were able to help GRCs gain access to Chief District Project Officers (CDPO), AWW supervisors, and AWWs. Building a relationship with the CDPOs helped facilitate their approvals for their staff to participate in and use government venues for GRC and community events. Implementing partners encouraged District level staff and GRCs to connect with AWWs and ASHAs by circulating their contact details. This facilitated collaborative planning sessions for community events targeting women and increased involvement of District-level bodies in community mobilization activities. AWWs used their network to generate interest from women, adolescent girls and children to participate in GRC activities.

> "In the pilot GRCs, the project made concerted efforts to engage these different actors [state, district community level entities] in dialogue and sit and plan together for community activities. This kind of engagement has not only helped build the resource base for GRCs but has also led to better health within the community."
> *– Mission Convergence Nodal Person*

Linkages with community-based and non-governmental organizations

With an established community presence, NGO and CBO involvement is essential to enable a health system to extend services to hard-to-reach populations such as those living in the urban slums. The project engaged a wide range of NGOs, CBOs and other grassroots partner organizations. These included: *Basti Vikas Samitis* (translated: self-help groups or SHGs); Resident Welfare Associations (RWA); Community Development Societies (CDS); *Mahila Mandals* (translated: female social clubs); and Youth Clubs. These groups have some influence over their community's perspectives and decisions about health issues.

Under the Health Systems 20/20 project, NGO and CBO participation multiplied the effectiveness of community mobilization activities to improve uptake of services. The project supported community level networking meetings to orient them to the project, Mission Convergence, and the contributions they could bring to the work of GRCs. Meetings included influential members of the community, political leaders, academicians, GRC beneficiaries, school children, Mahila Mandals, youth clubs, NGOs, and others. These meetings brought to light service delivery issues particularly important to the urban poor: the need for essential drugs and services close to home, convenient scheduling of services at times outside normal business hours, and access to quality care from concerned, client-friendly providers.

Developing strong networks at community level emphasized the collective power of CBOs and other community groups to demand higher quality health services and better accountability for health resources expended. Stronger networks also highlighted systemic barriers to collaboration. For example, a Health Department office order must be issued to PHCs and dispensaries before they can supply family planning products to Depots and GRCs. This requirement, which caused frequent delays in obtaining requisite approvals, created an inefficient supply chain for family planning products. PHC and dispensary staff also needed formal Health Department office approvals to participate in GRCs' activities and approvals were difficult to obtain in time for the event. Their subsequent absence at these events meant that they missed an opportunity to deliver services, products, and information. Similarly, AWC staff were required to get supervisor directives to attend events. In many

cases, by the time these directives were obtained, staff were unable to participate because they had committed to other activities and were no longer available.

4.2.2 ENHANCED GRC ACTIVITIES TO EXPAND ACCESS TO INSURANCE AND A CONTINUUM OF HEALTHCARE

Mission Convergence aims to expand access to existing government services and benefits. In the context of health, these largely include services provisioned directly through Municipal Corporation of Delhi (MCD) and Delhi Government dispensaries, hospitals, ASHAs, ANMs, Anganwadis and disease-specific programs such as the Revised National Tuberculosis Control Program (RNTCP) and the National Malaria Eradication Program (NMEP). Expanding coverage of financial protection schemes (e.g., RSBY, JSY, MAMTA) also figures prominently in meeting this objective. However, underutilization typifies many government facilities established to serve the urban poor. Low public awareness about facilities' services and perceptions about poor quality of services offered all factor into this problem.

Health Systems 20/20 sought to address these issues in collaboration with Mission Convergence by using innovative activities that brought a wider variety of specialized health services to the urban slums than would otherwise be available. Health *mela* (translated: health fair) exemplify the project's comprehensive approach to extending the continuity of care and facilitating linkages within the health system. OPD clinics held outside normal business hours and at Family Planning Depots were other facets to the approach. Curative care made available at the community level can increase the likelihood of tracking patients to complete treatment regimens. An efficient referral network of public and private health providers can ensure that the diverse health issues presenting are directed to the appropriate care and treatment in a timely manner. For these precise reasons, the project worked with numerous healthcare actors to increase the diversity of services available in the community.

> "Before the pilot, our OPDs were limited in nature and we were able to entertain specific number and cases [at melas]. Swasth really helped us broaden our services at the sessions by adding several diagnostic services including lab technicians. The test results along with the physical examination of the patient provided the doctors ample data to prescribe medicines for treating their conditions."
> *– AVBM Trust, GRC*

Health Mela

Prior to the Health Systems 20/20 activities, health mela followed a standard format and were organized every two months, according to the Mission Convergence mandate. They were not planned in a strategic manner that considered the needs of the population, nor did GRCs do much to promote the health camps. Assistance from the project encouraged the adoption of the mela as a comprehensive strategy to deliver a more wide-ranging services and health information. Like Mission Convergence itself, mela have the potential to be a single platform for converging the delivery of a broader continuum of care. The innovation HS20/20 introduced to the melas was a formal and collaborative planning process with all key stakeholders. Private institutions already linked to the public network including RSBY and MAMTA empanelled hospitals, trust hospitals and NGOs were previously minimally involved in the melas. Health Systems 20/20 facilitated their transition from simply being part of the referral system to being actively involved in planning and implementation of the mela.

Health Systems 20/20 technical assistance to build GRCs' capacity to organize successful health mela contributed to expanding the continuum of care for the hard-to-reach urban poor. GRCs were assisted to pilot and then refine over time an operational model for successful health melas. This model organizes activities under three components:

registration, services and health awareness. Health Systems 20/20 strengthened the service delivery and health awareness component of the health mela by engaging RSBY empanelled hospitals, charity institutions, independent practitioners, Government disease-specific national program teams and thematic NGOs. These organizations provided volunteers, in-kind donations, and other support to GRC melas and enabled GRCs to bring a wider array of services to marginalized communities.

The PPP model led to greater collaboration at melas and succeeded in both supplementing and expanding access to government health services. Enhanced service provider participation in melas made it possible for patients to access basic diagnostic services (e.g., check of height, weight, blood pressure, temperature, blood sugar, haemoglobin, HIV, malarial parasite, child growth trajectory). After registering and completing basic health checks, patients could consult a general physician, gynaecologist or paediatrician. Patients could then be immediately referred to other specialists, including nutritionists, or other diagnostic services available on-site. Close interaction with the Directorate of Health services (DHS) made possible the provision of essential medicines at melas and enabled patients to fill their prescriptions immediately, without a visit to different location. Public awareness activities ran concurrently with medical check-ups to expose patients and non-patients alike to information about important health issues in the community. Health Systems 20/20 facilitated linkages to theatre groups to put on entertaining health-themed skits and also incorporated health talks or quizzes delivered by GRC staff, an NGO, or volunteers into awareness activities. The integration of these preventive, diagnostic, and curative activities took advantage of every opportunity to improve health-seeking behaviours and produce better health outcomes.

New Models for Out-Patient Service Delivery

GRCs hosted biweekly OPD to deliver basic outpatient services to communities, principally targeting women and adolescents. The project supported new models for these OPD events and helped GRCs take a more pro-active approach to meeting patients' needs.

Linkages forged by the project among different health providers broadened the scope of OPD clinics to include obstetrical and gynaecological consultations as well as diagnostic services to check blood pressure, sugar and haemoglobin levels. Further, GRCs' expanded networks with private and public providers increased their ability to make appropriate referrals. The project also helped expand doctors' hours for consultations. The standard business hours of 9am to 5pm did not meet the needs of the working or migrant poor in Delhi slums. Health System 20/20 supported a model of after-hours OPD clinics. During two hour time blocks in the evening, women and adolescents could consult an accredited medical doctor, usually a gynaecologist, and receive free medicines. After consultation with the doctor, patients were able to access family planning products. By introducing these more comprehensive models of care and modelling the practice of building networks, Health Systems 20/20 helped build GRC capacity to meet all the needs of their target population.

Family Planning Depots

Another innovative approach to motivate community involvement around family planning was the introduction of family planning depots. Building on the existing resources of SHGs, the project helped GRCs to identify and recruit volunteers who would maintain a stock of family planning products in their homes. The products, procured from the nearby PHC, included sanitary napkins, condoms (government supply of Nirodh condoms), oral rehydration solution packets, and other items. Maintaining a regular supply of the health products from the PHC is a challenge, due to the approvals needed from the Health Department. Health System 20/20 implementing partners worked with PHCs to try to improve supply chain and

obtain directives needed in timely manner. The semi-literacy/ illiteracy of some volunteers has also hindered depot operations. However, overall depots are an innovative strategy to make health products more accessible to hard-to-reach populations in the urban slums.

4.2.3 PROMOTION OF COMMUNITY MOBILIZATION, HEALTH AWARENESS AND BEHAVIOUR CHANGE

No matter what insurance scheme or health service is offered, mobilizing prospective users to access the assistance is a critical part of the implementation process. RSBY in particular must overcome low enrolment to achieve its promise of providing financial protection for the poor against high OOP costs. Health Systems 20/20 identified community mobilization as a critical shortcoming in Mission Convergence work and offered a multitude of mobilization approaches to reach vulnerable groups in communities. Community women, pregnant and lactating women, adolescent girls, and AWWs (important for their health promotion role in the community) were frontline targets of mobilization activities. Community leaders, men, other influencing groups, and adolescent boys were secondary targets. Health Systems 20/20 community mobilization strategies involved both interpersonal and public approaches. Together, these took advantage of numerous community entry points to increase awareness of and use of RSBY and health services as well as promote healthier behaviours.

The selection and implementation of mobilization approaches was informed by a mapping of the available public and private health service/facilities and their staff (e.g., ASHA, ANM, AWW) as well as community resources (e.g., SHGs, RWAs). GRCs had not previously created any detailed resource map, though such maps proved to be useful to strengthen linkages between the GRCs and other health services available in the community. Appropriate communication strategies were informed by a Communication Needs Assessment (CNA). Through focus group discussions and interviews, the CNA assessed current knowledge, attitudes, values, beliefs and practices of the targeted population related to MCH; key barriers and motivating factors for promotion of healthy behaviours; communication gaps within communities, and key themes/messages and appropriate channels of communication among the audiences.

Women and Girl Empowerment around Health Issues

Women participate in a GRC-organized drawing competition about reproductive health

Because part of GRCs' mission is to promote women's empowerment, Health Systems 20/20 offered awareness strategies geared at specific subpopulations in the female demographic, including pregnant and lactating women and adolescent girls. Themed health awareness meetings for these groups covered topics including: safe motherhood; diabetes; child immunization; female foeticide, in Hindi *Kanya Bhrun Hayta;* TB; family planning; MCH insurance schemes; HIV/AIDS; breast cancer; and menstruation. Meetings were organized by GRCs with input and collaboration from various government functionaries operating in the vicinity, better integrating activities throughout the community health system. *Hoshiyar Maa-Swasthya Baccha* shows (translated: Smart Mother, Healthy Baby) showcasing healthy maternal and child health practices engaged larger groups of women in an interactive environment. Debate competitions for adolescent girls on female foeticide created a safe forum for girls to explore and voice opinions on this cultural issue. While designed to attract attention from particular segments of the community such as

children, pregnant women, and adolescent girls, these activities also achieved wider appeal among the whole community. Alongside these activities, GRCs' household visits to women reinforced the key health promotion messages delivered by the project via tailored information, education and communication (IEC) materials and public events.

The most remarkable aspects of these activities were that there was significant community ownership, and the events were highly cost effective. Organized in close coordination with and supported by AWCs, PHC staff, local NGO/CBOs, District Health Societies and NRHM, the activities utilized low or no cost community spaces such as an NGO office, AWC, GRC, etc. as their venue and leveraged volunteers from the healthcare community. This high level of community leadership and use of local resources increase the likelihood that the activities will be continued beyond Health System 20/20 involvement.

Awareness Raising of Public Health Issues

Health Systems 20/20 strengthened organisational systems and bolstered GRC staff skills to design and carry out public awareness activities. Health Systems 20/20 assistance consciously engaged specific GRC staff in planning and executing mobilization activities to build appropriate capacity across the organization. For instance, the project helped GRCs revise the job descriptions of SHG promoters to incorporate dissemination of information about upcoming GRC-organized health events. During planning meetings, SHG promoters learned more about welfare schemes especially those with MCH services (JSY, MAMTA and RSBY). SHG promoters also learned about health conditions to which the urban poor are particularly susceptible (e.g., pregnancy complications, communicable and infectious diseases), and the process of identifying and following-up referral cases for MCH services/schemes. They were then able to incorporate this information into their health-themed talks delivered to BPL and APL scheme cardholders. Health Systems 20/20 used similar approaches to build the capacity of GRC community mobilizers, nutritionists, and other staff to increase overall capacity within GRCs.

With greater capacity, GRCs were better able to plan and implement a wide range of awareness raising activities. Rallies were usually organized the day before a health mela or other significant event in order to mobilize the community and increase their uptake of the services to be made available. GRCs' preparations — announcements made through a public address system, publicity materials such as banners and fliers, and the rally organized in a public location — sparked greater community interest in the event. Rallies were organized during the late afternoon or early evening; doing so enabled GRC's message to reach a larger section of the community when working men and women returned home in the evening. Other IEC activities, including video presentations and street theatre performances, were also organized on a regular basis to promote awareness about health issues. GRCs procured basic IEC materials from various development agencies and government departments such as the Department of Health and Family Welfare, District NRHM cell, the Women and Child Development Department, and others. These materials were distributed to event participants to reinforce key messages on HIV/AIDS, safe motherhood, diabetes, child immunization, female foeticide, TB, FP and schemes like JSY, MAMTA, and RSBY.

Overall, generating awareness and mobilizing communities through rallies significantly contributed to the increase in the total number of beneficiaries served during health mela, nutrition camps, and OPD clinics. A greater number of people were therefore able to benefit from the consultative, diagnostic and curative services offered. Increased awareness also likely contributed to increased use of insurance schemes.

Behaviour Change

All community mobilization strategies and activities endeavoured to promote behaviour change that would lead to greater use of health insurance and health services and improve health outcomes. Those strategies were as comprehensive as possible, in terms of the health issues addressed, the stakeholders involved, and the channels used to motivate attitude and behaviour change. Health Systems 20/20 and Swasth designed, and delivered two comprehensive packages of activities for changing behaviours related to water-borne illness and anaemia prevention. These issues were health issues identified as high priority during the baseline assessment. The effectiveness of these packages was evaluated to determine if they are appropriate for scale up by GRCs.

Behaviour Change Case Study:
Improving Systems to Promote Safe Drinking Water Use

Working through implementing partner Swasth, Health Systems 20/20 tested a package of activities that GRCs could implement to promote the use of safe drinking water. The approach incorporated several steps:

- **Initial technical training for Swasth on safe water issues** –Swasth staff received training from a NGO specialising in water and sanitation and then trained GRC staff in turn.
- **Water situational assessment** — The assessment included (1) community meetings to understand the water situation and perceptions; (2) random water sampling using JalTARA Aquacheck vials to identify locations particularly vulnerable to water contamination; and (3) follow-up community meetings to substantiate vulnerable areas located by sampling.
- **Resource networking and linkage** — Swasth demonstrated to GRCs how to reach out to the Office of the Deputy Municipal Health Office (MHO) of Delhi and receive free chlorine tablets. GRCs then became a central point for chlorine distribution. GRCs also mapped other key NGOs and volunteers with whom to engage to distribute chlorine in the community.

"Chlorine available here" signage provided to ASHAs, NGOs, and community volunteers

- **Safe water message dissemination** — GRCs worked with other community-based entities, including ASHAs and NGOs, to incorporate safe water use messages as well as tablet distribution into those groups' activities.

GRC and Swasth staff used the result vials from the water quality assessments to demonstrate to community the differences in water quality and counter community perceptions about safe and unsafe drinking water. Using these tangible and easily understood exhibits, the interventions mobilized community demand for safe drinking water and chlorine tablets.

> "Despite the fact that these chlorine tablets were being provided free of charge by the Municipality, it was not until Swasth made that linkage did we realized that such free resources are available within the community and can be utilized for the benefit of the community."
> *– Manch and AVBM Trust Staff*

Increased demand for and use of safe water was measured by changes in the number of chlorine packets distributed throughout the community network. It was also verified by checking the water quality of households which received chlorine. Immediately prior to the intervention, the average number of chlorine packets distributed was 396 per month by community entities. At the height of the GRCs' implementing the package approach, 777 packets were distributed in a month. It is inferred that the community-based networks had become more efficient in delivering free stock. Swasth also visited a random sample of approximately 20 households which received chlorine and another 20 households that did not receive chlorine. While 26% of non-chlorine houses had water contamination, only 5.6% chlorine-using houses were affected. These rudimentary impact assessment activities suggest that the Health Systems 20/20 package approach was successful in improving the 'last mile' linkage from the MHO to communities to supply chlorine. It also strengthened collaboration to increase demand for safe water.

Behaviour Change Case Study:
Education and Prevention of Iron Deficiency Anaemia

Health Systems 20/20 selected iron deficiency anaemia as a health condition for a community-level package approach promoting preventive/curative care for at-risk women. Health Systems 20/20

supported Swasth to pilot the package consisting of the following components:

- **Training of Swasth health team on anaemia condition** — Swasth staff received training from a NGO specialising in anaemia prevention and then trained GRC staff in turn.
- **Community meetings focused on anaemia awareness-raising** — Swasth demonstrated to intervention GRCs how to plan and execute anaemia-focused events to raise awareness. GRC staff first only participated in the events, but then were encouraged to network with bridge schools and vocational training centres to hold additional events for students. The approach incorporated using visual flipcharts so that information could be relayed to both educated and low-literate individuals.
- **Community-level testing using simple pallor assessment tests** — After initial training on using haemoglobin colour scale (HbCS) tests, Swasth incorporated the test into the awareness raising intervention package. The tangible test results made the messages in community meetings more effective as they clearly displayed the health issue to participants.
- **Anaemia referral system strengthening** — Anaemia cases identified were referred to GRC OPD events and health camps using a referral slip designed for such cases. GRCs networked with the local PHC and health NGOs to ensure anaemia-related treatment and counselling were available at outreach events.
- **Use of street plays to increase awareness about iron deficiency anaemia** — A locally formed amateur street theatre group developed a street play, known as a nukkad nataks, to educate community members about anaemia. GRCs coordinated with the theatre group about the timing of health camps and melas so the plays would be shown to attending community members.

Though the approach was only piloted for five months, Swasth used a variety of evaluation activities to measure the effectiveness of the approach. Anaemia-focused awareness events such as community meetings and nukkad nataks outside the camp setting increased significantly over the period. Community mobilizers conducted 65 meetings each month, reaching 800-1000 in total. Total attendance during nukkad nataks was approximately 200 people. The team also conducted a mini-end line survey. Five severely anaemic women (HB level <= 8 mg / dL) randomly selected from the 4 worst hit areas of each catchment area were followed for 4 months. These women received an initial HbCS test at a community meeting and were counselled on behaviour change after their test. After four months, 75% of the women showed an improvement in their haemoglobin level. Swasth inquired about any modifications they had made to their behaviour changes since seeing their test and being initially counselled. The women reported behaviour changes such as eating a better diet with green vegetables and fruit juices, iron supplementation, and using an iron knife for food preparation. While not statistically significant, responses indicate that the anaemia awareness activities contributed to some behaviour change by tested women.

Nukkad natak show presented at a health camp

4.2.4 PRIVATE SECTOR ENGAGEMENT

One of the important innovations of the Health Systems 20/20 pilot in India was the engagement of a wide variety of private sector organizations and healthcare practitioners to expand access to and use of quality healthcare by the urban poor. The project's PPP model brought together private sector stakeholders — RSBY empanelled hospitals, specialty hospitals such as the Dr. Shroff Charitable Eye Hospital, the Rajiv Gandhi Cancer Hospital, and Leprosy Mission Hospital, CBOs, and NGOs — with District and Municipal Health Departments, government dispensaries, and other functionaries to expand the continuity of care available in the urban slums. The private sector played an important part in the success of strategies, from staffing specialists during health mela and OPD clinics to delivering workshops at GRCs on specific health themes to disseminating information about RSBY and other schemes,. Their engagement also facilitated better identification of and referrals for RSBY as well as referrals for ANC, reproductive health counselling, immunization campaigns, and other preventive health activities. Multi-sectoral coordination meetings introduced by Health Systems 20/20 were the venue for jointly planning these events and sharing information. The model appeared to be effective, in part, because both the public and private sector actors realized greater success in their health missions.

> "Our work with HLFPPT helped us understand that with planning, follow-up and relationship building, private sector providers can be a part of GRC activities at no additional cost."
> – Datamation Staff, GRC

4.2.5 INSTITUTIONALIZATION OF HEALTH SYSTEMS 20/20 STRATEGIES

Institutionalization of improvements demands moving beyond demonstration of effective health promotion interventions; it requires strategies to build and maintain local capacity to scale up and even improve upon these interventions. Health Systems 20/20 support to Mission Convergence integrated intensive capacity building activities for key actors involved in the implementation of Mission Convergence's action plan. The project supported the institutionalization of effective strategies within the system, starting with the PMU and pilot GRCs and then extending out to the full network of 104 GRCs under Mission Convergence supervision. Mission Convergence Program Managers have a greater understanding of RSBY and priority health issues affecting the urban poor, and are equipped to reinforce GRCs' skills. The project touched key levels of the health system — the State, District and community level. Capacity building strategies such as demonstrations, training and on-the-job mentoring facilitated a rapid transition from Health Systems 20/20 implementing partners' leadership to GRCs' ownership of the program design, plan, and implementation process.

Capacity Building within the Mission Convergence Program Management Unit

Mission Convergence Program Managers play a central role in supporting GRCs and Extension Centres to implement pro-poor activities promoting better health in Delhi's vulnerable urban communities. Program Managers are tasked to supervise and support GRC coordinators and community mobilizers in the many facets of their work. Health Systems 20/20 recognized the significance of this role and designed training activities and materials to enhance their management ability, particularly for health-related activities. Training events and training aids developed by Health Systems 20/20 explained in simple terms the healthcare delivery system in India along with the concepts of health financing and health insurance. They also covered Program Managers' important role in strengthening the welfare systems designed for the poor. Trainings also covered a broad array of prevailing health issues: MCH, reproductive health, HIV/AIDS, common cancers among women, vector-borne diseases, and other public health topics. Mentoring sessions stressed how GRCs' health promotion actions at the individual and community level are a key part of the health system as a whole.

The training programs led to two important outcomes. At the organizational level, Program Managers, now trained as Master Trainers, are well positioned to roll out training across GRCs to build their skills in health communication, counselling, and program coordination and implementation. This enables GNCTD to institutionalize the capacity improvements as a new structural element of the Mission Convergence program. At the individual level, building capacity of Mission Convergence Program Managers equipped them with better management skills, greater knowledge of key health issues affecting poor communities as well as a more informed understanding of RSBY and other health insurance schemes. With this increased technical competence, Managers could better support and supervise the work of the approximately 10-15 GRCs under their supervision. Post training, Managers reported increased appreciation for advocacy to encourage health system stakeholders to use the existing network of GRCs, NGOs, and community groups more effectively in order to advance comprehensive management of health issues in poor communities. Managers also recognized the need to continually support GRCs by providing information helpful to their achieving their health promotion objectives.

Capacity Building of GRCs

GRCs were given a prominent role in health insurance implementation, but it was necessary to build their capacity to enable them to fulfil this role. Health Systems 20/20's selected four GRCs and the communities they served were the locations to pilot test capacity building and health promotion/insurance promotion strategies. The capacity building strategy paired GRCs with Health Systems 20/20 and two strong implementing partners: HLFPPT and Swasth Foundation. These local organizations brought proven experience in community mobilization and health program management.

Health Systems 20/20 and its local partners used intensive, hands-on mentoring and practical, on the job training to build capacity. When the project introduced strategies for increasing demand for health insurance and primary healthcare, GRCs learned about ways to collaborate with TPAs and health insurance companies to jointly plan enrolment events to increase the number of people enrolled. Health Systems 20/20 and partners also demonstrated how to leverage the Mission Convergence GRC network to make a greater impact on health outcomes. GRCs were able to learn and practice new skills, and receive feedback from mentors on their performance, as they jointly planned and implemented project activities. On the job technical assistance to the four GRCs was paired with a foundational training program carried out by HLFPPT. Modules covered MCH, HIV/AIDS and project management. Emphasis on these topics reinforced GRCs' understanding of Mission Convergence program and health insurance schemes, the health situation of the urban poor, and community mobilization concepts. In this way, they systematically improved skills in advocacy, community mobilization, health promotion, and program management.

Health Systems 20/20 supported the development of easy-to-use reference materials including *Rashtriya Swasthya Bima Yojna: 2010 Guidebook* and *Basic Health for Gender Resource Centres*. These materials have proven valuable to GRCs as well as other groups involved in community mobilization and healthcare delivery. They offer information to help identify vulnerable families and guide them to access government health benefits for preventative and curative care.

Inauguration of RSBY Guidebook by Chief Minister Sheila Dikshit and USAID

During the pilot phase, an organic diffusion of some strategies, such as health mela and networking with the private sector health providers, occurred as non-intervention GRCs learned of these activities and adopted them without specific support from Health Systems 20/20. At the completion of the pilot phase, these and other strategies implemented successfully in the four pilot GRCs were rolled out to the remaining 100 GRCs in a succession of training events. The 2010 Guidebook was also distributed to all GRCs.

Capacity Building of Key Health Stakeholders

When the Mission Convergence program was introduced, many stakeholders and services providers in the public and private sectors focused narrowly on implementing their own programs and delivering their particular service — ANC, family planning products, nutritional support, etc. Although many stakeholders operated at the community level with similar or overlapping responsibilities, their programs were implemented vertically, separate from one another. In general, stakeholders did not value integrated programming or see the benefits of coordination. This promoted inefficiencies, missed opportunities, and redundancies.

Stakeholders engage in group work during a Health Systems 20/20 workshop on improving RSBY implementation

Health Systems 20/20 repeatedly supported formal and informal capacity building sessions, using GRCs as a coordinating mechanism to bring these stakeholders together. At the beginning of the project, stakeholders were oriented to Mission Convergence program. At a formal workshop, Health Systems 20/20 introduced stakeholders to RSBY and other government-sponsored health insurance schemes. At planning meetings, health melas, and other health promotion events, Health Systems 20/20 and GRCs educated stakeholders on demand mobilization approaches and the healthcare needs of the urban poor.

As a result of these consistent interactions, stakeholders' increased their knowledge of health insurance and health promotion. They recognized that integrated service delivery and cross-promotion of preventive health could improve health outcomes, and the GRC provided them with opportunities to apply their new perspective. As the GRCs embraced their coordination role, stakeholders from the public and private sector were able to collaborate to advance all their missions and objectives.

5. PROJECT IMPACT

5.1 END LINE SURVEY PROGRAM EVALUATION FINDINGS

The effects of Health Systems 20/20's technical assistance on access to financial protection and selected maternal and child health outcomes were assessed through analysis of two rounds of cross-sectional, household surveys. Using a two-stage sampling method, a total of 6,480 mothers were interviewed by local researchers using a pre-tested questionnaire. The sample comprised 1,620 mothers per intervention and control groups (at baseline and end line) who had given birth within one year prior to data collection. Statistical methods were used to assess changes between baseline and end line. First, bivariate relationships between dependent and independent variables were investigated using binary logistic regression model. A multivariate model was used to control for socio-demographic factors that may affect observed program outcomes. Key findings are highlighted below.

Improvements in Knowledge of Health Insurance Programs

A primary objective of Mission Convergence is to improve knowledge of health insurance programs among slum households. Based on the analysis, awareness of health insurance programs improved between 2009 and 2012. In particular, data from household surveys showed a 16 percentage point increase in the awareness of RSBY between baseline and end line (34% at baseline and 50% at end line), and a 5% point increase in respondents who have heard about CGHS (6% at baseline and 10% at end line) in the intervention group. By the end of the pilot project, more than two-thirds of the households (70%) in the intervention slums reported having heard of at least one insurance scheme, and 37% were aware of two or more insurance schemes.

Table 5 provides an overview of awareness of insurance schemes in the control and intervention slums. It should be noted that the Differences-in-differences analysis showed improvements in both the control and intervention GRC areas, suggesting that other factors may have contributed to increase in knowledge.

TABLE 5: PERCENTAGE OF HOUSEHOLDS THAT HAVE HEARD ABOUT RSBY (END LINE)

	Baseline	End line	Difference	P-value
Intervention Slums	34%	50%	.16	***
Control Slums	23%	46%	.22	***
Effect of the Intervention (Difference-in-difference):		Unadjusted	-.06	
		Adjusted	-.07	

TABLE 6: PERCENTAGE OF HOUSEHOLDS AWARE OF AT LEAST ONE INSURANCE SCHEME (END LINE)

	Baseline	End line	Difference	P-value
Intervention Slums	45%	70%	.25	***
Control Slums	32%	64%	.32	***
Effect of the Intervention (Difference-in-difference):		Unadjusted	-.08	
		Adjusted	-.07	

[1]Statistical significance of difference: ***p<0.01, **p<0.05, *p<0.1

Enrolment in Health Insurance Programs

Despite increased awareness of health insurance programs, data showed a decrease in enrolment in insurance schemes, in both control and intervention groups. In the baseline survey, 24% of respondents who have heard of the RSBY program enrolled in the scheme. However, at end line survey, less than one in ten women (9%) who have heard of the scheme enrolled in the program. For the other schemes — ESIS, CGHS, Mediclaim, and RSBY — no significant changes in enrolment were observed. One explanation for the observed change in RSBY might be related to implementation of the RSBY program. Based on in-depth interviews with Program Managers and households, issues with RSBY reimbursement were common at some empaneled hospitals. Hospitals, slow to be paid by insurance companies, turned away cardholders even though they were eligible for treatment. Public knowledge about this poor treatment possibly spread and potentially discourages others from seeking out the scheme.

TABLE 7: PERCENTAGE OF HOUSEHOLDS THAT ARE AWARE OF RSBY AND ENROLLED IN THE SCHEME (END LINE)

	Baseline	End line	Difference	P-value
Intervention Slums	24%	9%	-.15	***
Control Slums	22%	11%	-.11	***
Effect of the Intervention (Difference-in-difference):		Unadjusted	-.04	
		Adjusted	-.05	

[1]Statistical significance of difference: ***p<0.01, **p<0.05, *p<0.1

Utilization of Selected Maternal Services

Utilization of key maternal health services appeared to have improved between 2009 and 2012. A significantly greater proportion of respondents had three or more ANC check-ups, and delivered at either a government or private institutional (see Tables 8 and 9). More than 90 per cent of women received three or more ANC check-ups and 83% of women reported delivering at a health care institution. This association holds after adjusting for age, education and social-economic status.

TABLE 8: PERCENTAGE OF WOMEN WHO GAVE BIRTH AT A HEALTH SERVICE INSTITUTION WITHIN THE PAST YEAR (END LINE)

	Baseline	End line	Difference	P-value
Intervention Slums	72%	83%	.12	***
Control Slums	63%	72%	.09	***
Effect of the Intervention (Difference-in-difference):		Unadjusted	.02	
		Adjusted	.04	

[1]Statistical significance of difference: ***p<0.01, **p<0.05, *p<0.1

TABLE 9: PERCENTAGE OF WOMEN WHO HAVE RECEIVED THREE OR MORE ANC VISITS WITHIN THE PAST YEAR (END LINE)

	Baseline	End line	Difference	P-value
Intervention Slums	73%	91%	.18	
Control Slums	70%	87%	.17	
Effect of the Intervention (Difference-in-difference):		Unadjusted	.09	
		Adjusted	.07	

[1]Statistical significance of difference: ***p<0.01, **p<0.05, *p<0.1

5.2 QUALITATIVE RESEARCH AND ANECDOTAL EVIDENCE OF PROJECT IMPACT

Certain weak aspects of Health Systems 20/20 baseline survey design had to be replicated for the end line survey for reasons of survey integrity. This limits the project's ability to truly arrive at a measure of program effectiveness. In addition, the short duration of the project makes it difficult to validate the full institutionalization of approaches. In order to complement the quantitative end line findings, Health Systems 20/20 undertook a qualitative field research activity to ascertain and highlight the impacts of capacity building activities for GRCs. Intensive focus groups were organized with important stakeholders in the pilot project, including: Mission Convergence staff; pilot GRCs; implementing partners HLFPPT and Swasth Foundation; and private service providers involved in extending the continuity of care to urban slum dwellers.

5.2.1 NOTABLE ACHIEVEMENTS

Conclusions drawn from the series of stakeholder conversions supported the assertion that strategies introduced by Health Systems 20/20 were successful in enhancing the capacity of pilot GRCs to perform their health-related mandate. GRC capacity was specifically enhanced with regard to improving knowledge/awareness among the community on key health issues, and providing better access to and utilization of health services and government-sponsored health insurance. Additionally, the pilot helped increase the visibility of GRCs within the community and made community members as well as other stakeholders from the public and private sector aware of the valuable work GRCs carry out. This was a common theme that was highlighted by all four pilot GRCs.

> "*Before the pilot, many people from our community did not know that we existed. It was only after we did the 'mega' health camps in collaboration with Health Systems 20/20 during the pilot phase did people start asking us about our work, the services we provide. We are grateful to Health Systems 20/20 and HLFPPT and for showing us how to create awareness among the community on health issues."* — Datamation staff member

Visit by USAID Assistant Administrator Dr. Ariel Pablos-Mendez to Dr. A.V. Baliga Memorial Trust, a Health Systems 20/20 intervention GRC

Consensus among the pilot GRCs was also that the project's focused technical assistance enhanced their capacity to design and implement health interventions, thereby leading to a greater awareness about health issues among the community. The Mission Convergence Nodal Person was also highly appreciative of the technical assistance and acknowledged that it was the first systematic assistance received for a sustained period of time from an external agency.

> "*The pilot was successful in strengthening GRCs and by establishing linkages with other service providers and promoting health seeking behaviour among the community. The IEC materials developed specifically for the GRCs were simple, easy to understand and replicate. The MCH trainings held for the GRCs were also useful in increasing their knowledge on these issues."* — Mission Convergence Nodal Person

One of the key contributions of the pilot was demonstrating to GRCs how to cultivate useful and sustainable linkages with private sector organizations, including: private hospitals; NGOs and community organizations such as Basti Vikas Samiti; RWA; ASHAs; and AWW; in addition to relationships with district and municipal departments including CDMOs, government dispensaries, etc. Many of these linkages were the result of an introductory email or phone call made by implementing partners which blossomed into collaboration during health mela, OPD clinics, or other GRC activities.

> "*We received a cold call from Swasth; they told us about the work that they were doing with their GRCs and asked us to participate. We work well with GRCs such as AVBM and Manch whenever we go there for conducting cancer screening sessions, including breast exams, pap smears and oral cancer screening. The community mobilizers ensure that people show up for screenings. We also conduct trainings for the community mobilizers to help them screen and identify and refer high risk cases for further investigation."* — Rajiv Gandhi Cancer Hospital staff member

> *"Through Swasth we got linked to Shroff Eye Care and they started holding monthly screening camps. Our relationship with them is on-going and they often come here to organize eye check-up camps. Through Swasth we also got to know Naz Foundation which works on HIV/AIDS and SEWA, a non-profit organization who holds trainings on microfinance for us. Before the pilot we did not know that these resources existed and utilizing these kinds of connections was not a predominant part of our planning."* — MANCH staff

Both implementing partners, Swasth and HLFPPT, worked extensively on demand-side mobilization with their GRC counterparts to improve the utilization and uptake of health services available in the catchment area. The pilot showcased how GRCs can use multiple community mobilization strategies to connect with the community. These strategies were effective in strengthening the GRCs' existing activities such as health camps, OPD clinics, and nutrition camps thereby leading to improved awareness and positive response from the community on health issues. Integration of previously overlooked mobilization strategies — awareness rallies, thematic shows, using a public address system to announce big events, school-focused events, and distributing simple IEC materials on health issues in Hindi — increased GRCs' ability to reach a wider section of the population and get them involved.

It is not possible for a GRC alone to provide all the services required by vulnerable communities such as those living in the urban slums. The needs are great and diverse, the financial and human resources weak, and the physical environment extremely challenging. Yet, the collaboration fostered by Health Systems 20/20 among the different community-based actors, government entities and GRCs is an important step toward intensifying GRCs' impact. Coordination meetings at GRCs charted a path toward improved utilization of available health systems and structures by those in need.

5.2.2 HURDLES TO CONTINUING SUCCESS

Human Resources

Limited resources, especially manpower to continually plan, coordinate, and execute activities as well assist individual households with their specific needs, is a major on-going problem for GRCs. With a mandate that extends well beyond health, GRC staff have limited time and health experience to focus exclusively on building their own capacity in health programming. Health Systems 20/20 augmented GRC staff by supporting the hiring of a second dedicated community mobilizer during the pilot period. This model has clear drawbacks. First, Mission Convergence cannot shoulder this cost for all 104 GRCs in its

network. Second, the line between ***doing with*** rather than ***doing for*** the counterpart GRCs was sometimes difficult for implementing partners to maintain when GRCs' human resource needs were so great. Finally, the investment into relationship building between GRC and the outside technical assistance provider was time-consuming.

> *"It took some time to build up trust between the sub contractor's staff and the GRC staff. While at first we were a bit hesitant about having someone from the outside come and tell us what to do, with time and after having worked with the HLFPPT team for a while, we realized that they were only interested in helping us, making our job easier."* — MVS staff

Fragile Status of Institutionalization

Health Systems 20/20 wrapped up pilot activities after only 11 months of implementation. At the time of project design, it was impossible to foresee activities of a longer duration because of funding and contract limitations. Although training and capacity building activities were delivered to both the Mission Convergence PMU and the entire GRC network to create the enabling environment for strategies to be rolled out widely, a systematic plan for assuring regular technical assistance and monitoring of both cadres of workers was not developed. It is optimistic to assume that the project built a strong enough technical foundation within Mission Convergence to facilitate continuing and thorough support to all GRCs.

> *"The short time period did not give us much time to create a full blue print for the GRCs for future planning and engage them in this kind of future planning."* — HLFPPT

Health Insurance Implementation Complexities

Working at the community or "micro" level, Health Systems 20/20 helped build the capacity of Mission Convergence and GRCs to improve the on-the-ground implementation of RSBY. Dissemination of easy-to-understand RSBY guidebooks and pamphlets helped increase community awareness and promote greater utilization of available financial risk protection targeting the poor. The project also designed and distributed the RSBY enrolment register to facilitate enrolment tracking and reporting to the DoL. It also organized pre-enrolment micro workshops for GRCs to prepare them for their role in the enrolment process. However, in spite of these commendable efforts, RSBY is characterized by continuing low enrolment. This problem is the results of on-going macro-level coordination and communication problems with regard to how hospitals will be paid, BPL beneficiaries tracked, and TPAs held accountable for poor performance. These issues work counter to GRCs' ramped up efforts to mobilize greater demand.

> *"We have a good relationship with [pilot GRC] ABVM which was facilitated by Swasth and we are happy attend their health camps and provide free services, but on the RSBY front we still have payments outstanding and this is making it difficult for us to honour RSBY card holders."* — Navjeevan Hospital staff, a RSBY empanelled hospital

The crux of the matter is that in order to enhance utilization and access of RSBY by the BPL population, there are certain fundamental implementation issues that were beyond the scope of Health Systems 20/20 and can only be tackled only through high level engagement of Mission Convergence and the Departments of Health and Labour and Employment.

6. SUSTAINING SUCCESS: LESSONS LEARNED AND RECOMMENDATIONS

6.1 LESSONS LEARNED IN IMPLEMENTING HEALTH SYSTEMS STRENGTHENING INTERVENTIONS IN THE URBAN CONTEXT

Effective implementation of financial risk protection for the poor is a complex issue requiring a multi-faceted approach to create the necessary enabling environment.

Preliminary discussions between the Government of Delhi and Health Systems 20/20 about possible strategies to improve the effectiveness of social protection schemes initially singled out low insurance utilization as the core issue to be addressed. Yet, the project did not define in narrow terms the root causes of this problem. Instead, the project conducted an informal process mapping exercise with stakeholders to identify the multiple variables impacting health insurance utilization. Possible strategies to address the problem were proposed and tested. This holistic approach helped the project pinpoint the appropriate strategies to achieve the desired impact. In the end, the strategies supported by Health Systems 20/20 touched on numerous gaps in the health system for the urban poor that limited the poor's awareness of, preference for, and active use of financial risk protection and health services.

While a holistic approach was important in this case, the project's overall ability to make a demonstrable impact was limited by the short duration of interventions. The project was envisioned as a pilot to test whether the combination of strategies could work to overcome health system barriers for the poor. Four GRCs received intensive technical assistance from Health Systems 20/20 in just under a year. Although the remaining GRCs did benefit from training once the strategies were validated, there was not time in the project to determine whether all GRCs had the capacity to implement the strategies on their own.

Initial buy-in from Mission Convergence and highly active participation throughout the project was instrumental in the project's success.

An extremely high level of engagement between Mission Convergence and Health Systems 20/20 was essential to set the right tone for changes to be made within current systems for both RSBY implementation and health service delivery for the poor. Numerous formal and informal meetings between stakeholders ensured that everyone was on the same page and would support any agreed upon changes. This highly collaborative atmosphere also extended to the GRCs themselves. GRCs were extremely open to technical assistance. They showed an unabashed recognition that they needed help in order to be more efficient and effective in their work. Thus, it was possible to create the overall environment conducive to organizational and system-wide changes.

A flexible implementation plan left room for implementing partners and GRCs to innovate when needed in response to unforeseen priorities.

When preparing for and then implementing the field portion of the pilot, Health Systems 20/20 staff took a non-prescriptive approach when working with implementing partners. After developing a shared vision of desired project outcomes, partners were given the space to collaborate with the GRCs in ways that they felt would be the most beneficial. This flexible approach created the space for partners to innovate. For example, when community assessments completed by Swasth and its GRC counterparts revealed poor water quality issues, Swasth adjusted the scope of its planned interventions to promote safe water use. Also, Swasth's experience procuring low-cost medicines from manufacturers and then passing on the savings to consumers in the urban slums was an innovation not initially envisioned to be incorporated. But this was done through the alternate OPD model that Health Systems 20/20 supported. In both instances, important information was obtained to improve future community mobilization strategies and well as shape strategies to reduce OOP expenses for medicines.

Even projects aiming to make a difference at the implementation level must consider how high-level policies impact implementation.

From its inception, Health Systems 20/20's collaboration with Mission Convergence aimed to address ground-level barriers to RBSY implementation. There was mutual interest in breaking down these barriers and extending financial risk protection to the poor. In viewing on-the-ground implementation gaps as the greatest problem, Health Systems 20/20 and Mission Convergence assumed that everything was operating smoothly at the higher policy level with regard to RSBY itself. Unfortunately, the project learned only in the course of implementation that this was not the case; providers and empaneled hospitals were not being reimbursed properly and the poor, even when enrolled in RSBY, were not able to access care. They were being turned away by empaneled providers. It quickly became clear that complex issues at the policy level also needed to be resolved, but this was beyond the scope of the project.

Setting targets for improved organizational performance is important to ensuring that health systems strengthening efforts create the requisite enabling environment to sustain improved health outcomes.

In aiming to improve access to and use of financial risk protection and a broader continuum of health services for the poor, Health Systems 20/20 looked to make a measurable impact on health outcomes. Baseline and end line surveys sought to show changes in behaviours and health outcomes such as increased percentage of institutional deliveries and reduced infant and child mortality. However, the short duration of the project made it very difficult to meaningfully measure such changes.

It would have been more beneficial to establish performance targets for the Mission Convergence PMU team and assisted GRCs. In doing so, it would have been possible to track changes in organizational maturity that would indicate that the organizations are in a good place to continue Health Systems 20/20 strategies after the pilot.

Involving the private sector in health care for the poor is not just about communicating the population's unique needs; it is about helping the private sector to see opportunities to deliver services cost-effectively to new market.

There is significant diversity among those who fall under the private sector banner. Individuals, companies, NGOs, and CBOs are all included in this group, but their health mission and means to achieve it often differ. Health Systems 20/20 put this knowledge into action in its private sector engagement strategies. The project found it very important to communicate with this group's members on the terms that resonated most loudly for each

member. For some providers, the catalyst for participation with Health Systems 20/20 was the knowledge that they would find ready beneficiaries for health services when GRCs were involved on the community mobilization side. For others, such as empaneled hospitals, confidence was raised in the RSBY system when they knew GRCs and implementing partners were acting as advocates in the payment process. A variety of strategies is necessary to incentivize private sector participation in health system strengthening efforts.

6.2 RECOMMENDATIONS FOR SUSTAINING AND SCALING-UP HEALTH INSURANCE FOR THE POOR IN INDIA

Utilize process mapping to identify bottlenecks within the health system and the health insurance mechanism

Health Systems 20/20 used an informal process mapping exercise to understand who the major actors in RSBY implementation are as well as their intended role. The documentation of RSBY implementation in Delhi helped pinpoint where bottlenecks were occurring, identify the relevant stakeholders, and define the challenges that needed to be overcome. From this analysis, the project team was able to design interventions that involved the relevant stakeholders and addressed the specific implementation blocks.

In the RSBY experience, the mapping uncovered key areas for improvement: improving RSBY enrolment rates; strengthening education and outreach activities; strengthening Mission Convergence management oversight of RSBY implementation; and strengthening the benefits offered to RSBY beneficiaries.

Align Mission Convergence human resource workforce skills with the programs coordinated under its umbrella

The Mission Convergence brings together programs from nine different line departments, each which have a particular technical focus. In addition to health programs, Mission Convergence Program Managers, DRC Coordinators, Mother NGOs, and GRCs are expected to have a firm grasp of the other technical programs areas, such as women and child development, urban development, food and supplies, education, and SC/ST/OBC welfare.

With such varying technical responsibilities, it is essential that the Mission Convergence aligns its human resources to the nine priority technical areas. Increasing PMU managers' and GRC staff technical knowledge of health issues such as health financing, HIV/AIDS, TB, MCH, and ANC helps enhance their capacity to be more effective program health implementers and community healthcare liaisons. Further, ensuring that Mission Convergence technical staff have strong management skills will help foster more efficient, effective and sustainable program efforts.

Establish and adopt a clear capacity building approach for Mission Convergence GRCs to strengthen their organizational maturity and chart their path to becoming fully integrated within the healthcare system

With 104 GRCs in the Mission Convergence network, their management and technical capacity varies immensely. Some may have staff with health experience; others may not have health programming skills at all. Therefore, scaling-up Health Systems 20/20 strategies to all GRCs must take into account these differences in health knowledge and management experience. A comprehensive scale-up plan should be guided by an overall vision for organizational maturity which is supported by specific and regular capacity building activities.

The spectrum of skills-building activities — from twinning and mentoring to staffing support to training and refresher trainings — should all be considered. Then, progress on performance targets should be measured periodically to take stock of each GRC's readiness to implement their health mission without intensive technical support.

Establish a robust monitoring and evaluation system to enable long-term tracking of how interventions impact health outcomes

The success of financial risk protection will not be measured only in terms of lowered OOP cost for health services. Nor will it be measured by the number of people enrolled. Similarly, the effectiveness of health service delivery in meeting the needs of vulnerable populations cannot be measured by a mere enumeration of people served. In the end, overall effectiveness of health programs is driven by how well they succeed at improving health outcomes. For this reason, further efforts to scale-up the Health Systems 20/20 strategies for better RSBY implementation and health service delivery should be accompanied by a comprehensive monitoring and evaluation plan. This plan would highlight program deficiencies and promote strategy adjustments when necessary.

Rectify organizational relationship challenges between RSBY implementation stakeholders prior to moving ahead with RSBY scale-up

Health Systems 20/20 strategies worked diligently to increase the urban poor's access and use of government-sponsored financial risk protection in general, and RSBY in particular. However, roadblocks ensued between RSBY implementers. For example, some health providers experienced a disincentive to participate in the scheme, despite being empanelled to participate in the RSBY scheme, as they were not being reimbursed in a timely manner. As a result, providers refused new RSBY clients. In tandem with this issue, TPAs, which are responsible for enrolling beneficiaries, would often not show up at the enrolment sites organized by the GRCs. The result was a lost opportunity to enrol potential RSBY beneficiaries. The combination of these factors created a lack of confidence in RSBY among the poor: RSBY looks less like a viable scheme through which they can access healthcare. These illustrative RSBY structural issues point to a misalignment of incentives on all sides.

Prior to further scale-up of RSBY, attention should be paid to reaching consensus among the Department of Labour, the insurers, TPAs, and empaneled hospitals about their roles and responsibilities with regard to RSBY. This should be coupled with clear systems to monitor and enforce performance of any party involved in RSBY implementation. A system for handling disputes and patient grievances needs to be firmly established before more beneficiaries are encouraged to access RSBY.

Research the root causes of low enrolment in and use of health insurance by the urban poor so strategies to improve healthcare access are targeted and aligned to achieve health objectives

The benefits of catastrophic health insurance for the poor are indisputable. The costs associated with doctor's fees, laboratory tests, medicines, transportation and lost wages can quickly overwhelm the meagre resources of vulnerable families and mire them deeper into poverty. Catastrophic insurance for hospitalization events is therefore critical.

However, having health insurance available to the poor is not enough. Many locations, including India and Delhi, specifically, have health insurance mechanisms available for the poor. Yet, those mechanisms suffer from either low enrolment or, if people are enrolled, low use of the insurance. Understanding the reasons for this is critical.

For example, in some settings, the beneficiaries may not understand well enough the benefits of insurance. Therefore, strategies to mitigate low enrolment or low-use of insurance may be increasing targeted BCC or education activities. In other settings, the perceived quality of insured services may be a reason for low enrolment and, therefore strategies to improve quality, or the perception of quality, are critical.

In other settings, it may be that the benefit package is not attractive. Often, people assume they will not have catastrophic health issues, so an insurance policy focusing only on catastrophic coverage would be unnecessary. They may instead want to see in the benefits design services that are more readily needed, such as primary healthcare. A better benefits design may alone be what it takes to encourage people to enrol in health insurance, or use their insurance when accessing the healthcare system.

Understanding and addressing the issue of weak demand for health insurance is also critical. Because the urban poor have little exposure to health insurance and financial risk protection, any intervention aiming to provide insurance must consider how the poor will receive information about and enrol in insurance. It must also reflect on how to continually support the poor so they get the most value out of their participation. In the context of the Delhi slums, ensuring strong coordination among GRCs, NGOs, and health service providers in their delivery of healthcare and information emerged as an imperative.

As India eyes adopting UHC, it will be ever important to ensure that health financing strategies, such as insurance, are designed in a way that overcomes enrolment and use challenges. This will help to overcome the “last mile” hurdle and bring benefits to the most vulnerable and hard-to-reach in the urban slums.

Research value-for-money in healthcare service delivery to better target financing strategies for optimal return-on-investment

There is significant support for UHC in India and substantial financial resources available to help attain it through government budgets as well as donor support. However, these resources are finite. Therefore, understanding how those resources should be invested into the health system to maximize return is essential.

To understand this better, research should identify the principal factors driving how, when, where, and why the poor seek out healthcare services. Although there is high interest among donors to support UHC, health insurance, and performance-based incentives, the question is whether these approaches are generating the greatest possible impact in terms of access, use and outcomes among the poor. Understanding the drivers will provide better data upon which to design stronger health financing programs. In turn, the research will make possible a more efficient use of the financial resources available within the health sector.

Link health insurance efforts to other health programs to improve continuity of care among the urban poor and maximize investments

Health insurance alone does not equate to access and use of health services. Further, free public health services do not equal access and use of health services. Many efforts are being pursued to both improve financial risk protection among the poor, as well as improve primary healthcare. However, few efforts are working collaboratively to realize common health goals.

Linking health financing strategies, such as insurance, to other health improvement efforts can help facilitate continuity of care among the beneficiaries and can be mutually beneficial for several stakeholders. For example, ensuring families have access to primary and preventative healthcare services is beneficial to insurance companies, as it can reduce the

overall costs of care. Similarly, ensuring that households have access to financial risk protection can reduce OOP expenditures on health and minimize the economic effects of catastrophic healthcare.

In addition, offering “bundled” services (such as catastrophic health coverage, plus coverage for primary healthcare) can make management of health programs more efficient and ultimately cut down on overhead costs. For example, linking services to create a bundled package of services may be more attractive to beneficiaries, thereby encouraging participation in the insurance scheme. Administratively, fewer resources may be needed to market bundled products, as marketing can be done jointly (insurance plus primary healthcare). Likewise, fewer costs would be needed to manage the enrolment process, as families who sign up for one, automatically are signed up for the other.

Explore the potential for the Mission Convergence and other PPP models to be scaled-up more widely in Delhi and in Indian other states

The Health Systems 20/20 pilot project honed in on an innovative PPP model with the Mission Convergence. With Mission Convergence, the project was able to leverage the GRC network to facilitate greater access to other public and private organizations within the healthcare system. This, in turn, helped bring needed health services deeper into the urban communities. Emphasis on strong linkages, enhanced networking and coordination among health organizations avoided duplicity of efforts and improved resource efficiencies.

This approach was only piloted in a small area of Delhi. More research should be done to ascertain the feasibility of replicating approaches across all Mission Convergence GRCs as well as in other state health systems. The model requires coordination with and capacity building of numerous stakeholders and implementers. Therefore, a better understanding of other existing programs and their structure is required to know how the model could be integrated with a high degree of success.

Furthermore, there are a number of other PPP models meriting review: from NGOs managing government health centres; to contracting-in of NGOs’ health facilities to join them to the public network; from private providers contracted by the public sector to work part-time in urban communities; to NGO-run mobile health clinics stocked by publicly-procured medicines and supplies. Each presents a distinctive opportunity to extend healthcare services to hard-to-reach populations. Research will serve the purpose of identifying the optimal situation in which to apply each to create a stronger health system for the urban poor.

ANNEX A: BIBILIOGRAPHY

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